



US009155654B2

(12) **United States Patent**  
**Tu et al.**

(10) **Patent No.:** **US 9,155,654 B2**  
(45) **Date of Patent:** **Oct. 13, 2015**

(54) **OCULAR SYSTEM WITH ANCHORING  
IMPLANT AND THERAPEUTIC AGENT**

(56) **References Cited**

U.S. PATENT DOCUMENTS

(75) Inventors: **Hosheng Tu**, Newport Coast, CA (US);  
**Jason Artof**, Westlake Village, CA (US);  
**David Steven Haffner**, Mission Viejo,  
CA (US); **Gregory T. Smedley**, Aliso  
Viejo, CA (US); **Barbara A. Niksch**,  
Capistrano Beach, CA (US)

3,788,327 A	1/1974	Donowitz et al.
4,037,604 A	7/1977	Newkirk
4,113,088 A	9/1978	Binkhorst
4,168,697 A	9/1979	Cantekin
4,175,563 A	11/1979	Arenberg et al.
4,366,582 A	1/1983	Faulkner
4,402,681 A	9/1983	Haas et al.
4,428,746 A	1/1984	Mendez

(Continued)

(73) Assignee: **GLAUKOS CORPORATION**, Laguna  
Hills, CA (US)

(\*) Notice: Subject to any disclaimer, the term of this  
patent is extended or adjusted under 35  
U.S.C. 154(b) by 491 days.

FOREIGN PATENT DOCUMENTS

AU	200072059 A1	7/2001
CA	2244646 A1	2/1999

(Continued)

(21) Appl. No.: **13/399,760**

(22) Filed: **Feb. 17, 2012**

(65) **Prior Publication Data**

US 2012/0253258 A1 Oct. 4, 2012

**Related U.S. Application Data**

(60) Continuation of application No. 12/246,448, filed on  
Oct. 6, 2008, now Pat. No. 8,118,768, which is a  
division of application No. 11/083,713, filed on Mar.  
18, 2005, now Pat. No. 7,431,710, which is a

(Continued)

(51) **Int. Cl.**

**A61M 19/00** (2006.01)

**A61F 9/007** (2006.01)

**A61K 31/215** (2006.01)

(52) **U.S. Cl.**

CPC ..... **A61F 9/00781** (2013.01); **A61K 31/215**  
(2013.01)

(58) **Field of Classification Search**

USPC ..... 604/7-10, 264; 606/153

See application file for complete search history.

OTHER PUBLICATIONS

(Edited by) Strange, Kevin, *Cellular and Molecular Physiology of  
Cell Volume Regulation*, Library of Congress Cataloging in-Publica-  
tion Data, CRC Press, Inc., 1994, pp. 312-321.

(Continued)

*Primary Examiner* — Leslie Deak

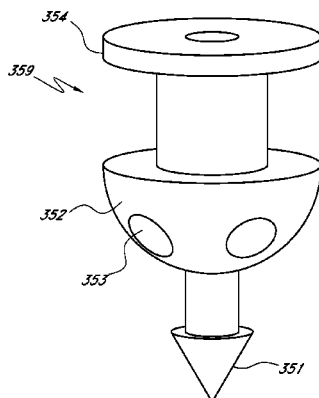
(74) *Attorney, Agent, or Firm* — Knobbe Martens Olson &  
Bear LLP

(57)

**ABSTRACT**

Ocular implants, delivery devices and methods for treating  
ocular disorders are disclosed. One method involves inserting  
an implant on one side of an eye. The implant has an anchor  
on a distal end portion and an outlet opening that is disposed  
proximal of the anchor. The implant is advanced across the  
eye to the other side of the eye. The anchor is inserted into eye  
tissue on the other side of the eye. A therapeutic agent is  
eluted using the implant.

**16 Claims, 60 Drawing Sheets**



**Related U.S. Application Data**

continuation-in-part of application No. 10/634,213, filed on Aug. 5, 2003, now Pat. No. 7,867,186, which is a continuation-in-part of application No. 10/118,578, filed on Apr. 8, 2002, now Pat. No. 7,135,009, said application No. 11/083,713 is a continuation-in-part of application No. 10/667,580, filed on Sep. 22, 2003, now Pat. No. 7,488,303, said application No. 12/246,448 is a continuation-in-part of application No. 11/598,542, filed on Nov. 13, 2006, now Pat. No. 7,563,241, which is a continuation of application No. 10/118,578, filed on Apr. 8, 2002, now Pat. No. 7,135,009.

- (60) Provisional application No. 60/281,973, filed on Apr. 7, 2001.

(56) **References Cited**

## U.S. PATENT DOCUMENTS

4,501,274	A	2/1985	Skjaerpe	5,443,505	A	8/1995	Wong et al.
4,521,210	A	6/1985	Wong	5,454,796	A	10/1995	Krupin
4,554,918	A	11/1985	White	5,466,233	A *	11/1995	Weiner et al. .... 604/890.1
4,560,383	A	12/1985	Leiske	5,472,440	A	12/1995	Beckman
4,583,224	A	4/1986	Ishii et al.	5,476,445	A	12/1995	Baerveldt et al.
4,604,087	A	8/1986	Joseph	5,486,165	A	1/1996	Stegmann
4,632,842	A	12/1986	Karwoski et al.	5,502,052	A	3/1996	DeSantis
4,634,418	A	1/1987	Binder	5,516,522	A	5/1996	Peyman et al.
4,718,907	A	1/1988	Karwoski et al.	5,520,631	A	5/1996	Nordquist et al.
4,722,724	A	2/1988	Schocket	5,547,993	A	8/1996	Miki
4,733,665	A	3/1988	Palmaz	5,557,453	A	9/1996	Schalz et al.
4,750,901	A	6/1988	Moltena	5,558,629	A	9/1996	Baerveldt et al.
4,787,885	A	11/1988	Binder	5,558,630	A	9/1996	Fisher
4,804,382	A	2/1989	Turina et al.	5,558,637	A	9/1996	Allonen et al.
4,820,626	A	4/1989	Williams et al.	5,562,641	A	10/1996	Flomenblit et al.
4,826,478	A	5/1989	Schocket	RE35,390	E	12/1996	Smith
4,846,172	A	7/1989	Berlin	5,599,534	A	2/1997	Himmelstein et al.
4,846,793	A	7/1989	Leonard et al.	5,601,094	A	2/1997	Reiss
4,853,224	A	8/1989	Wong	5,601,549	A	2/1997	Miyagi
4,863,457	A	9/1989	Lee	5,626,558	A	5/1997	Suson
4,883,864	A	11/1989	Scholz	5,626,559	A	5/1997	Solomon
4,886,488	A	12/1989	White	5,629,008	A	5/1997	Lee
4,900,300	A	2/1990	Lee	5,639,278	A	6/1997	Dereume et al.
4,936,825	A	6/1990	Ungerleider	5,651,783	A	7/1997	Reynard
4,946,436	A	8/1990	Smith	5,652,014	A	7/1997	Galin et al.
4,968,296	A	11/1990	Ritch et al.	5,652,236	A	7/1997	Krauss
4,997,652	A	3/1991	Wong	5,663,205	A	9/1997	Ogawa et al.
5,005,577	A	4/1991	Frenekl	5,665,114	A	9/1997	Weadock et al.
5,041,081	A	8/1991	Odrich	5,670,161	A	9/1997	Healy et al.
5,073,163	A	12/1991	Lippman	5,676,679	A	10/1997	Simon et al.
5,092,837	A	3/1992	Ritch et al.	5,681,275	A	10/1997	Ahmed
5,095,887	A	3/1992	Leon et al.	5,681,323	A	10/1997	Arick
5,098,443	A	3/1992	Parel et al.	5,702,414	A	12/1997	Richter et al.
5,127,901	A	7/1992	Odrich	5,702,419	A	12/1997	Berry et al.
5,129,895	A	7/1992	Vassiliadis et al.	5,704,907	A	1/1998	Nordquist et al.
5,164,188	A	11/1992	Wong	5,713,844	A	2/1998	Peyman
5,171,213	A	12/1992	Price, Jr.	5,723,005	A	3/1998	Herrick
5,178,604	A	1/1993	Baerveldt et al.	5,741,333	A	4/1998	Frid
5,180,362	A	1/1993	Worst	5,743,868	A	4/1998	Brown et al.
5,207,685	A	5/1993	Cinberg et al.	5,752,928	A	5/1998	de Rouillac et al.
5,246,451	A	9/1993	Trescony et al.	5,766,242	A	6/1998	Wong et al.
5,290,295	A	3/1994	Querals et al.	5,766,243	A	6/1998	Christensen et al.
5,300,020	A	4/1994	L'Esperance, Jr.	5,767,079	A	6/1998	Glaser et al.
5,318,513	A	6/1994	Leib et al.	5,785,674	A	7/1998	Mateen
5,324,306	A	6/1994	Makower et al.	5,807,302	A	9/1998	Wandel
5,334,137	A	8/1994	Freeman	5,810,870	A	9/1998	Myers et al.
5,338,291	A	8/1994	Speckman et al.	5,814,620	A	9/1998	Robinson et al.
5,346,464	A	9/1994	Camras	5,824,072	A	10/1998	Wong
5,360,399	A	11/1994	Stegmann	5,830,139	A	11/1998	Abrue
5,370,607	A	12/1994	Memmen	5,830,171	A	11/1998	Wallace
5,370,641	A	12/1994	O'Donnell, Jr.	5,833,694	A	11/1998	Poncet
5,372,577	A	12/1994	Ungerleider	5,836,939	A	11/1998	Negus et al.
5,397,300	A	3/1995	Baerveldt et al.	5,840,041	A	11/1998	Petter et al.
5,433,701	A	7/1995	Rubinstein	5,865,831	A	2/1999	Cozean et al.
				5,868,697	A	2/1999	Richter et al.
				5,869,468	A	2/1999	Freeman
				5,879,319	A	3/1999	Pynson et al.
				5,882,327	A	3/1999	Jacob
				5,886,822	A	3/1999	Spitzer
				5,891,084	A	4/1999	Lee
				5,893,837	A	4/1999	Eagles et al.
				5,908,449	A	6/1999	Bruchman et al.
				5,925,342	A	7/1999	Adorante et al.
				5,932,299	A	8/1999	Katoot
				5,952,378	A	9/1999	Stjerschantz et al.
				5,968,058	A	10/1999	Richter et al.
				5,980,928	A	11/1999	Terry
				5,981,598	A	11/1999	Tatton
				6,004,302	A	12/1999	Brierley
				6,007,510	A	12/1999	Nigam
				6,007,511	A	12/1999	Prywes
				6,033,418	A	3/2000	Gordon et al.
				6,033,434	A	3/2000	Borghi
				6,045,557	A	4/2000	White et al.
				6,050,970	A	4/2000	Baerveldt
				6,050,999	A	4/2000	Paraschac et al.
				6,059,772	A	5/2000	Hsia et al.
				6,059,812	A	5/2000	Clerc et al.
				6,060,463	A	5/2000	Freeman

(56)

**References Cited****U.S. PATENT DOCUMENTS**

6,063,116	A	5/2000	Kelleher
6,063,396	A	5/2000	Kelleher
6,071,286	A	6/2000	Mawad
6,077,299	A	6/2000	Adelberg et al.
6,102,045	A	8/2000	Nordquist et al.
6,110,912	A	8/2000	Kaufman et al.
6,123,668	A	9/2000	Abreu
6,142,990	A	11/2000	Burk
6,159,458	A	12/2000	Bowman et al.
6,165,210	A	12/2000	Lau et al.
6,168,575	B1	1/2001	Soltanpour
6,174,305	B1	1/2001	Mikus et al.
6,177,427	B1	1/2001	Clark et al.
6,184,250	B1	2/2001	Klimko et al.
6,186,974	B1	2/2001	Allan et al.
6,187,016	B1	2/2001	Hedges et al.
6,193,656	B1	2/2001	Jeffries et al.
6,194,415	B1	2/2001	Wheeler et al.
6,197,056	B1	3/2001	Schachar
6,201,001	B1	3/2001	Wang et al.
6,203,513	B1	3/2001	Yaron et al.
6,217,895	B1	4/2001	Guo et al.
6,228,873	B1	5/2001	Brandt et al.
6,231,597	B1	5/2001	Deem et al.
6,231,853	B1	5/2001	Hillman et al.
6,241,721	B1	6/2001	Cozean et al.
6,251,090	B1	6/2001	Avery et al.
6,254,612	B1	7/2001	Hieshima
6,261,256	B1	7/2001	Ahmed
6,266,182	B1	7/2001	Morita
6,268,398	B1	7/2001	Ghosh et al.
6,274,138	B1	8/2001	Bandman et al.
6,287,256	B1	9/2001	Park et al.
6,287,313	B1	9/2001	Sasso
6,299,895	B1	10/2001	Hamman et al.
6,306,120	B1	10/2001	Tan
6,331,313	B1	12/2001	Wong et al.
6,342,058	B1	1/2002	Portney
6,348,042	B1	2/2002	Warren, Jr.
6,375,642	B1	4/2002	Grieshaber et al.
6,378,526	B1	4/2002	Bowman et al.
6,413,540	B1	7/2002	Yaacobi
6,416,777	B1	7/2002	Yaacobi
6,428,501	B1	8/2002	Reynard
6,436,427	B1	8/2002	Hamman et al.
6,450,937	B1	9/2002	Mercereau et al.
6,450,984	B1	9/2002	Lynch et al.
6,464,724	B1	10/2002	Lynch et al.
6,471,666	B1	10/2002	Odrich
6,494,857	B1	12/2002	Neuhann
6,524,275	B1	2/2003	Lynch et al.
6,530,896	B1	3/2003	Elliott
6,533,768	B1 *	3/2003	Hill ..... 604/521
6,544,249	B1	4/2003	Yu et al.
6,548,078	B2	4/2003	Guo et al.
6,558,342	B1	5/2003	Yaron et al.
6,579,235	B1	6/2003	Abita et al.
6,585,680	B2	7/2003	Bugge
6,589,203	B1	7/2003	Mitrev
6,595,945	B2	7/2003	Brown
6,596,296	B1	7/2003	Nelson et al.
6,605,053	B1	8/2003	Kamm et al.
6,623,283	B1	9/2003	Lynch et al.
6,626,858	B2	9/2003	Lynch et al.
6,629,981	B2	10/2003	Bui et al.
6,638,239	B1	10/2003	Bergheim et al.
6,666,841	B2	12/2003	Gharib et al.
6,699,211	B2	3/2004	Savage
6,726,676	B2	4/2004	Stegmann et al.
D490,152	S	5/2004	Myall et al.
6,730,056	B1	5/2004	Ghaem et al.
6,736,791	B1	5/2004	Tu et al.
6,780,164	B2	8/2004	Bergheim et al.
6,780,165	B2	8/2004	Kadziauskas et al.
6,783,544	B2	8/2004	Lynch et al.

6,827,699	B2	12/2004	Lynch et al.
6,827,700	B2	12/2004	Lynch et al.
6,893,413	B2	5/2005	Martin
6,955,656	B2	10/2005	Bergheim et al.
6,962,573	B1	11/2005	Wilcox
6,981,958	B1	1/2006	Gharib et al.
7,033,603	B2	4/2006	Nelson et al.
7,041,077	B2	5/2006	Shields
7,077,821	B2	7/2006	Durgin
7,094,225	B2	8/2006	Tu et al.
7,101,402	B2	9/2006	Phelps et al.
7,135,009	B2	11/2006	Tu et al.
7,291,125	B2	11/2007	Coroneo
7,662,123	B2	2/2010	Shields
7,708,711	B2	5/2010	Tu et al.
2002/0013546	A1	1/2002	Grieshaber et al.
2002/0013572	A1	1/2002	Berlin
2002/0026200	A1	2/2002	Savage
2002/0072673	A1	6/2002	Yamamoto et al.
2002/0099434	A1	7/2002	Buscemi et al.
2002/0128704	A1	9/2002	Daum et al.
2002/0133168	A1	9/2002	Smedley et al.
2002/0143284	A1	10/2002	Tu et al.
2002/0169130	A1	11/2002	Tu et al.
2002/0188308	A1	12/2002	Tu et al.
2003/0009124	A1	1/2003	Lynch et al.
2003/0055372	A1	3/2003	Lynch et al.
2003/0060752	A1	3/2003	Bergheim et al.
2003/0069637	A1	4/2003	Lynch et al.
2003/0088260	A1	5/2003	Smedley et al.
2003/0093084	A1	5/2003	Nissan et al.
2003/0097151	A1	5/2003	Smedley et al.
2003/0120200	A1	6/2003	Bergheim et al.
2003/0181848	A1	9/2003	Bergheim et al.
2003/0187384	A1	10/2003	Bergheim et al.
2003/0187385	A1	10/2003	Bergheim et al.
2003/0212383	A1	11/2003	Cote et al.
2003/0220602	A1	11/2003	Lynch et al.
2003/0220603	A1	11/2003	Lynch et al.
2003/0229303	A1	12/2003	Haffner et al.
2003/0236483	A1	12/2003	Ren
2003/0236484	A1	12/2003	Lynch et al.
2004/0024345	A1	2/2004	Gharib et al.
2004/0050392	A1	3/2004	Tu et al.
2004/0092548	A1	5/2004	Embleton et al.
2004/0102729	A1	5/2004	Haffner et al.
2004/0111050	A1	6/2004	Smedley et al.
2004/0127843	A1	7/2004	Tu et al.
2004/0225250	A1	11/2004	Yablonski
2004/0254520	A1	12/2004	Porteous et al.
2004/0254521	A1	12/2004	Simon
2005/0038334	A1	2/2005	Lynch et al.
2005/0049578	A1	3/2005	Tu et al.
2005/0107734	A1	5/2005	Coroneo
2005/0119737	A1	6/2005	Bene et al.
2005/0192527	A1	9/2005	Gharib et al.
2006/0069340	A1	3/2006	Simon
2007/0106236	A1	5/2007	Coroneo
2007/0191863	A1	8/2007	De Juan, Jr. et al.
2007/0202186	A1	8/2007	Yamamoto et al.
2007/0233037	A1	10/2007	Gifford, III et al.
2008/0027304	A1	1/2008	Pardo et al.
2008/0058704	A1	3/2008	Hee et al.
2008/0306429	A1	12/2008	Shields et al.
2009/0043321	A1	2/2009	Conston et al.
2010/0173866	A1	7/2010	Hee et al.
2010/0274259	A1	10/2010	Yaron et al.

**FOREIGN PATENT DOCUMENTS**

DE	198 40 047	A1	3/2000
EP	0 858 788	A1	8/1998
EP	0 898 947	A2	3/1999
EP	1 114 627	A1	7/2001
FR	2 710 269	A1	3/1995
FR	2 721 499		12/1995
GB	2 296 663	A	7/1996
JP	11-123205		5/1999
WO	WO 89/00869	A1	2/1989

(56)

## References Cited

## FOREIGN PATENT DOCUMENTS

WO	WO 91/18568	A1	12/1991
WO	WO 92/19294	A1	11/1992
WO	WO 94/13234	A1	6/1994
WO	WO 94/21205	A1	9/1994
WO	WO 95/08310	A1	3/1995
WO	WO 96/20742	A1	7/1996
WO	WO 98/30181	A1	7/1998
WO	WO 98/35639	A1	8/1998
WO	WO 99/26567	A1	6/1999
WO	WO 99/30641	A1	6/1999
WO	WO 99/38470	A2	8/1999
WO	WO 99/38470	A3	8/1999
WO	WO 00/13627	A1	3/2000
WO	WO 00/64389	A1	11/2000
WO	WO 00/64390	A1	11/2000
WO	WO 00/64391	A1	11/2000
WO	WO 00/64393	A1	11/2000
WO	WO 00/72788	A1	12/2000
WO	WO 01/50943	A2	7/2001
WO	WO 01/78631	A2	10/2001
WO	WO 01/78656	A2	10/2001
WO	WO 02/074052	A2	9/2002
WO	WO 03/015659	A2	2/2003
WO	WO 03/073968	A2	9/2003
WO	WO 2009/012406	A1	1/2009

## OTHER PUBLICATIONS

Bahler, Cindy K. ,BS, et al., *Trabecular Bypass Stents Decrease Intraocular Pressure in Cultured Human Anterior Segments*, American Journal of Ophthalmology, Dec. 2004, vol. 138, pp. 988-994.

Dorland's Illustrated Medical Dictionary, 28th Edition, Philadelphia: W.B. Saunders Company, 1994, p. 167.

Ellis, Richard A. , M.D., *Reduction of Intraocular Pressure Using Plastics in Surgery*, American Journal of Ophthalmology, Third Series Founded by Edward Jackson, vol. 50, Jul.-Dec. 1960, 12 pages.

Fletcher, Daniel A. , Ph.D., et al., *Intravascular Drug Delivery With a Pulsed Liquid Microjet*, (Reprinted) Arch Ophthalmology; vol. 120, Sep. 2002, pp. 1206-1208.

Grant, W.M. MD, Further Studies on Facility of Flow Through the Trabecular Meshwork, *AMA Archives of Ophthalmology*, Oct. 1958, vol. 60, pp. 523-533.

Grierson, I., et al., *Age-related Changes in the Canal of Schlemm*, Exp. Eye Res., 1984, vol. 39, pp. 505-512.

Hill, R.A., et al., Free-electron Laser (FEL) Ablation of Ocular Tissues, *Lasers Med Sci* 1998, vol. 13, pp. 219-226.

Hill, Richard A., MD, et al., Laser Trabecular Ablation (LTA), *Lasers in Surgery and Medicine*, 1991, vol. 11, pp. 341-346.

Hoerauf, Hans, et al., *Slit-lamp-adapted optical coherence tomography of the anterior segment*, Graefe's Arch Clin Exp Ophthalmol, 2000, vol. 238, pp. 8-18.

Hoskins, et al. "Aqueous Humor Outflow", Becker-Shaffer's Diagnosis and Therapy of the Glaucomas, 6<sup>th</sup> Edition, Chapter 4, pp. 41-66, 1989.

Jacobi, Phillip C., MD, et al., Microendoscopic Trabecular Surgery in Glaucoma Management, *Ophthalmology*, 1999 vol. 106, No. 3, pp. 538-544.

Jacobi, Phillip C., MD, et al., Bimanual Trabecular Aspiration in Pseudoexfoliation Glaucoma, *Ophthalmology*, 1998 vol. 105, No. 5, May 1998, pp. 886-894.

Jacobi, Phillip C., MD, et al., Gonioscurettage for Removing Trabecular Meshwork: Clinical Results of a new Surgical Technique Advanced Chronic Open-Angle Glaucoma, *American Journal of Ophthalmology*, May 1999, pp. 505-510.

Jocson, Vincente, L., M.D.; *Air Trabeculotomy*; American Journal of Ophthalmology: vol. 79, No. 1, Jan.-Jun. 1975; pp. 107-111.

Johnstone, M.A., et al., *American Glaucoma Society, 12<sup>th</sup> Annual Meeting, Cylindrical Tubular Structures Spanning from Trabecular Meshwork Across SC*, Laboratory Studies with SEM, TEM and Tracers Correlated with Clinical Findings, Feb. 28, 2002 to Mar. 3, 2002, p. 39.

Jordan, Jens F. ,MD, et al., *A Novel Approach to Suprachoroidal Drainage for the Surgical Treatment of Intractable Glaucoma*, J Glaucoma, vol. 15, No. 3, Jun. 2006, pp. 200-205.

Jordan, Jens F., et al., *Cyclodialysis ab inferno as a surgical approach to intractable glaucoma*, Graefe's Arch Clin Exp Ophthalmol (2007) 245:1071-1076.

Kampik, Anselm, et al., Nutzen und Risiken Augenärztlicher Therapie, *Hauptreferate der XXXIII, Essener Fortbildung für Augenärzte*, Dec. 1998. (English translated version enclosed "Benefits and Risks of Ophthalmological Therapy").

Katz L. Jay ,MD, A Call for Innovative Operations for Glaucoma, *Arch Ophthalmology*, Mar. 2000, vol. 118, pp. 412-413.

Kim et al., Controlled Drug Release from an Ocular Implant: An Evaluation Using Dynamic Three-Dimensional Magnetic Resonance Imaging, *Investigative Ophthalmology & Visual Science*, Aug. 2004, vol. 45, No. 8, 2722-2731.

Klemm, M., et al., *Experimental use of space-retaining substances with extended duration: functional and morphological results*, Graefe's Arch Clin Exp Ophthalmol (1995) 233:592-597.

Luntz, Maurice H., MD, et al., Trabeculotomy AB Externo & Trabeculectomy in Congenital and Adult-Onset Glaucoma, *American Journal of Ophthalmology*, Feb. 1977, vol. 83, No. 2, pp. 174-179.

Matsumoto, Yasuhiro, et al., *Trabecular Meshwork Phagocytosis in Glaucomatous Eyes*, Ophthalmologica 1977, vol. 211, pp. 147-152.

Nickells, Robert W., et al., *Apoptosis of Retinal Ganglion Cells in Glaucoma: An Update of the Molecular Pathways Involved in Cell Death*, Survey of Ophthalmology, vol. 43, Supplement 1, Jun. 1999, pp. S-151 through S-161.

Olsen et al., Cannulation of the Suprachoroidal Space: A Novel Drug Delivery Methodology to the Posterior Segment, *American Journal of Ophthalmology*, Nov. 2006, 777-787.

Online encyclopedia article "Hyaluronan," section on "Medical Applications" accessed Monday, Sep. 27, 2010. [http://en.wikipedia.org/wiki/Hyaluronic\\_acid](http://en.wikipedia.org/wiki/Hyaluronic_acid).

Pinnas, Gerald, MD, *Cyclodialysis With Teflon Tube Implants*, American Journal of Ophthalmology, vol. 68, Jul.-Dec. 1969, 6 pages.

Portney, Gerald, MD, *Silicone Elastomer Implantation Cyclodialysis, A Negative Report*, Archives of Ophthalmology, vol. 89 Jan. 1973, 3 pages.

Putney, Luanna K., et al., *Intracellular Cl Regulates Na—K—Cl Cotransport Activity in Human Trabecular Meshwork Cells*, 1999 American Physiological Society, Sep. 1999, pp. C373 through C383.

Radhakrishnan, Sumita, et al., *Real-Time Optical Coherence Tomography of the Anterior Segment at 1310 nm*, Arch Ophthalmology, Aug. 2001, vol. 119, pp. 1179-1185.

Ritch, et al., "Uveoscleral Outflow", The Glaucomas, 2<sup>nd</sup> Edition, Chapter 15, pp. 337-343, 1996.

Rohen, Johannes W. , et al., *Anatomy of the Aqueous Outflow Channels*, Glaucoma, vol. 1, Chapter 14, pp. 277-296, Edited by J.E. Cairns, Grune & Stratton, Harcourt Brace Jovanovich Publishers, 1986.

Rosenberg, et al., "Implants in Glaucoma Surgery", The Glaucomas, 1996, Chapter 88, pp. 1783-1807 (27 pages).

Rowan, Patrick J. , MD, *Combined Cyclodialysis and Cataract Surgery*, Ophthalmic Surgery and Lasers, Dec. 1998, vol. 29, No. 12, pp. 962-968 (9 pages).

Schwartz, Arthur L. ,MD, et al., Trabecular Surgery, *Arch Ophthalmol*, vol. 92, Aug. 1974, pp. 134-138.

Shields, "Aqueous Humor Dynamics", Textbook of Glaucoma, 4<sup>th</sup> Edition, Chapter 2, pp. 5-31, 1998.

Shields, M. Bruce ,MD, *A Study Guide for Glaucoma: Aqueous Humor Dynamics*, Copyright 1982, pp. 6-43.

(56)

**References Cited**

## OTHER PUBLICATIONS

Spiegel, Detlev , *7 chirurgische Glaukomtherapie*, Dec. 1998, pp. 79-88 (English translation enclosed).

Spiegel, Detlev ,MD, et al., Schlemm's Canal Implant: A New Method to Lower Intraocular Pressure in Patients With POAG?, *Ophthalmic Surgery and Lasers*, Jun. 1999, vol. 30, No. 6, pp. 492-494.

Tatton, W.G., *Apoptotic Mechanisms in Neurodegeneration: Possible Relevance to Glaucoma*, *European Journal of Ophthalmology*, Jan.-Mar. 1999, vol. 9, Supplement 1, pp. S22 through S29.

Tatton, William, et al., *Maintaining Mitochondrial Membrane Impermeability: An Opportunity for New Therapy in Glaucoma*, *Survey of Ophthalmology*, vol. 45, Supplement 3, May 2001, pp. S277 through S283.

Troncoso, Manuel U., Tantalum implants for inducing hypotony, *American Journal of Ophthalmology*, vol. 32, No. 4, Apr. 1949, pp. 499-508 (11 pages).

Troncoso, Manuel Uribe , M.D., Cyclodialysis with Insertion of a Metal Implant in the Treatment of Glaucoma, Read before the Section on Ophthalmology at the Ninetieth Annual Session of the American Medical Association, St. Louis, May 17, 1939, *Archives of Ophthalmology*, pp. 270-300, downloaded from [www.archophthalmol.com](http://www.archophthalmol.com) on Aug. 5, 2010.

U.S. Appl. No. 09/452,963, filed Dec. 2, 1999. Title: *Expandable/Retractable Stent for Venous and Valvular Annulus Use*.

Wagner, Justin A., et al., *Characterization of Uveoscleral Outflow in Enucleated Porcine Eyes Perfused Under Constant Pressure*, *Invest Ophthalmol Vis Sci*, Sep. 2004; 45(9): 3203-3206 (9 pages).

Zhou, Jianbo, PhD, et al., *A Trabecular Bypass Flow Hypothesis*, Feb. 2005, vol. 14 No. 1, pp. 74-83.

\* cited by examiner

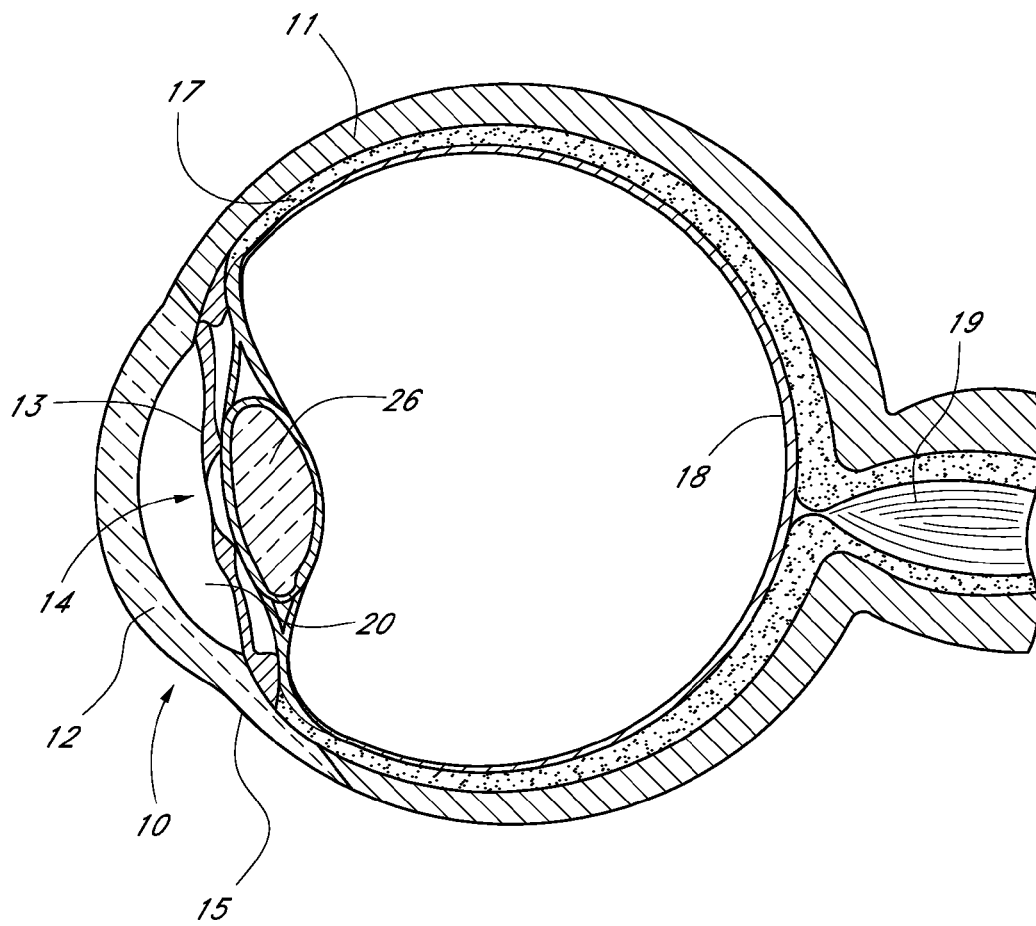


FIG. 1

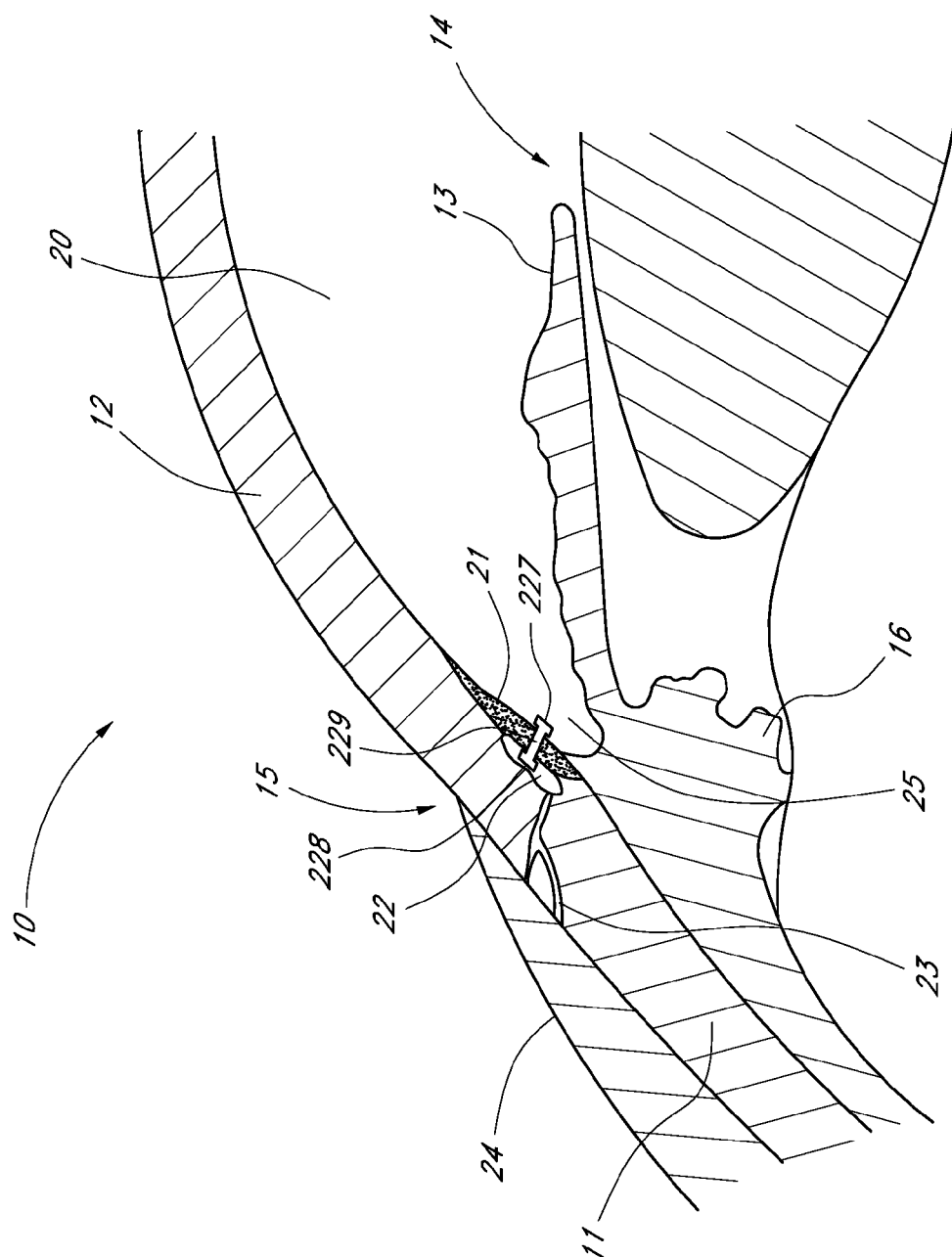


FIG. 2

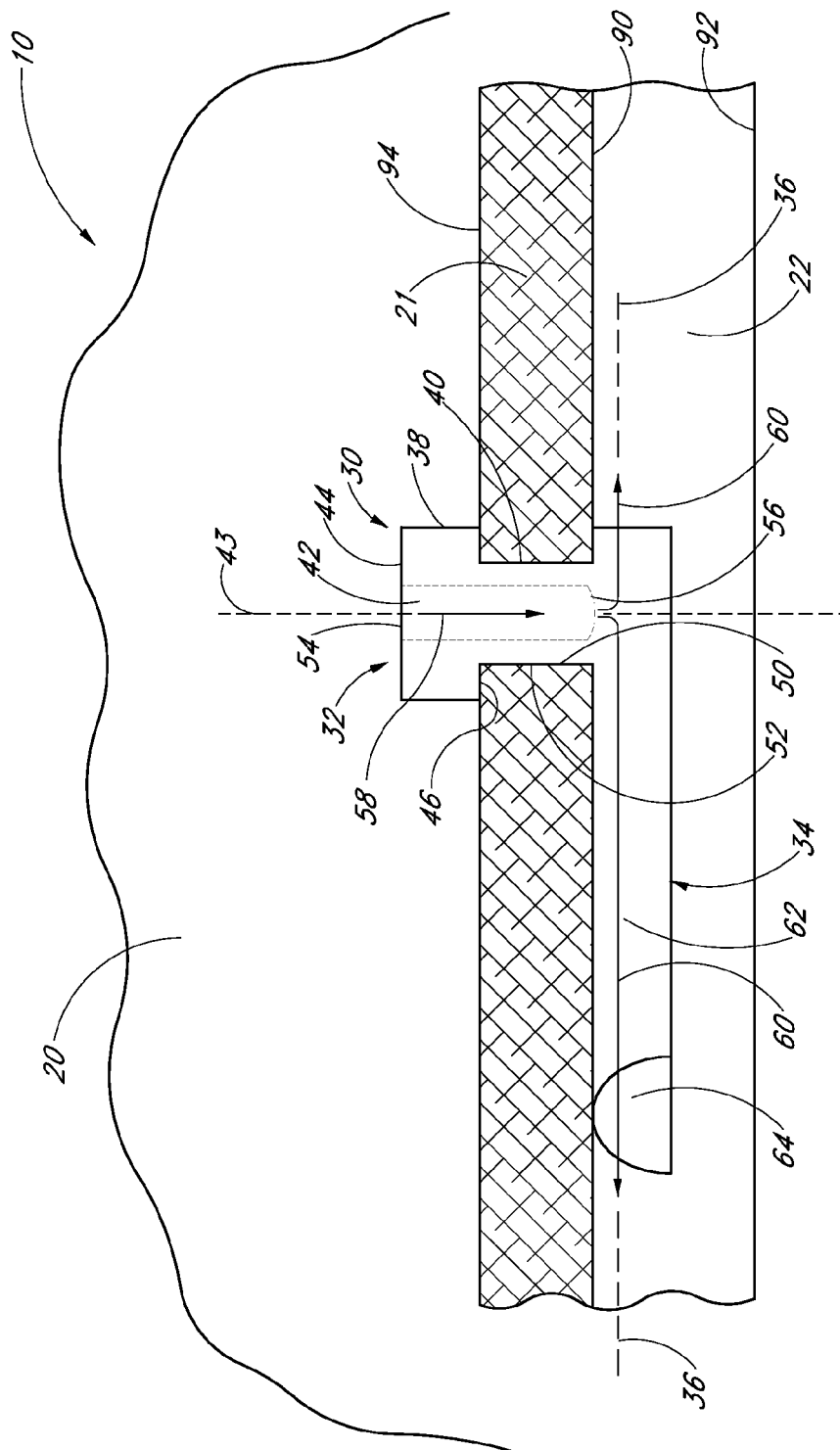
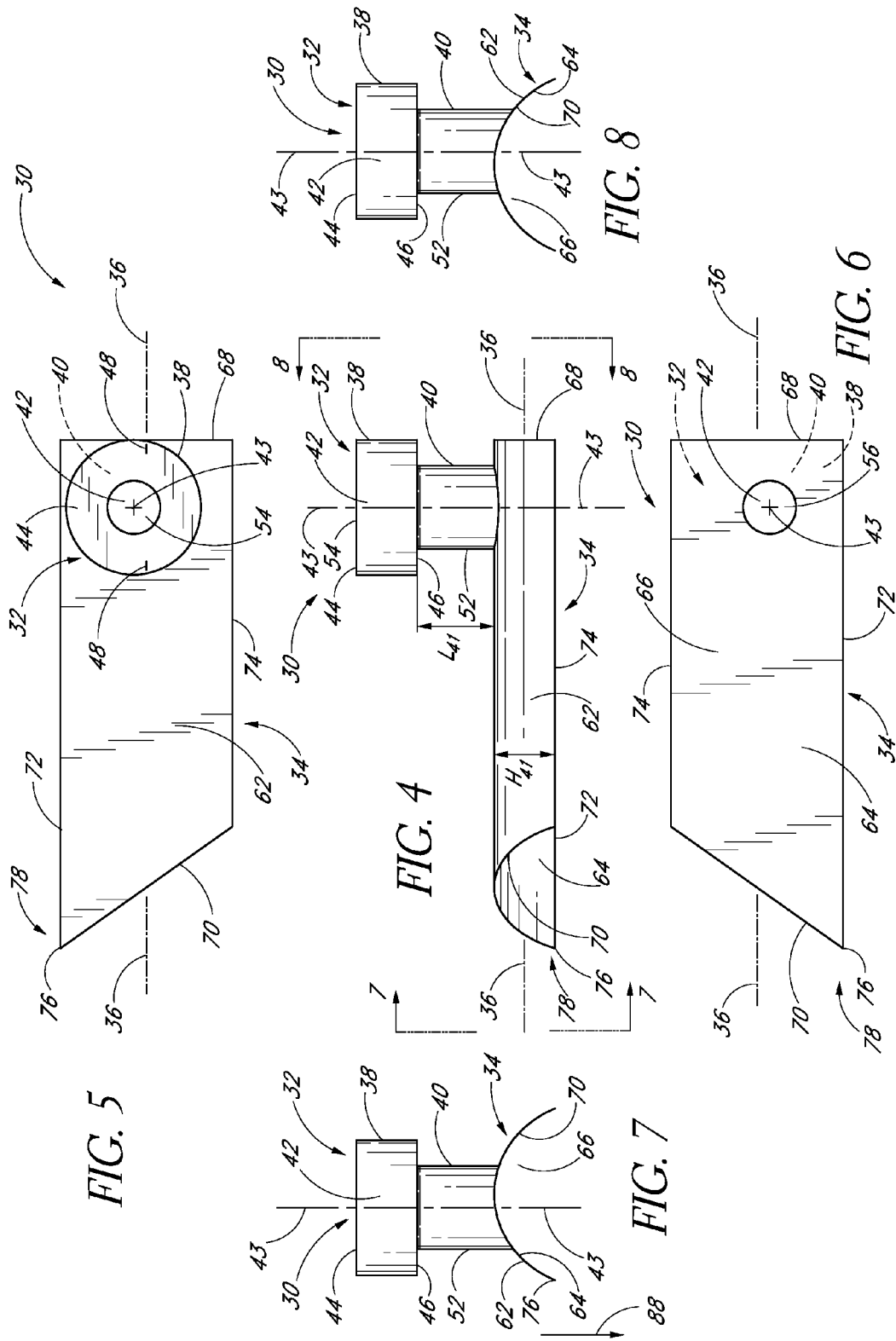


FIG. 3





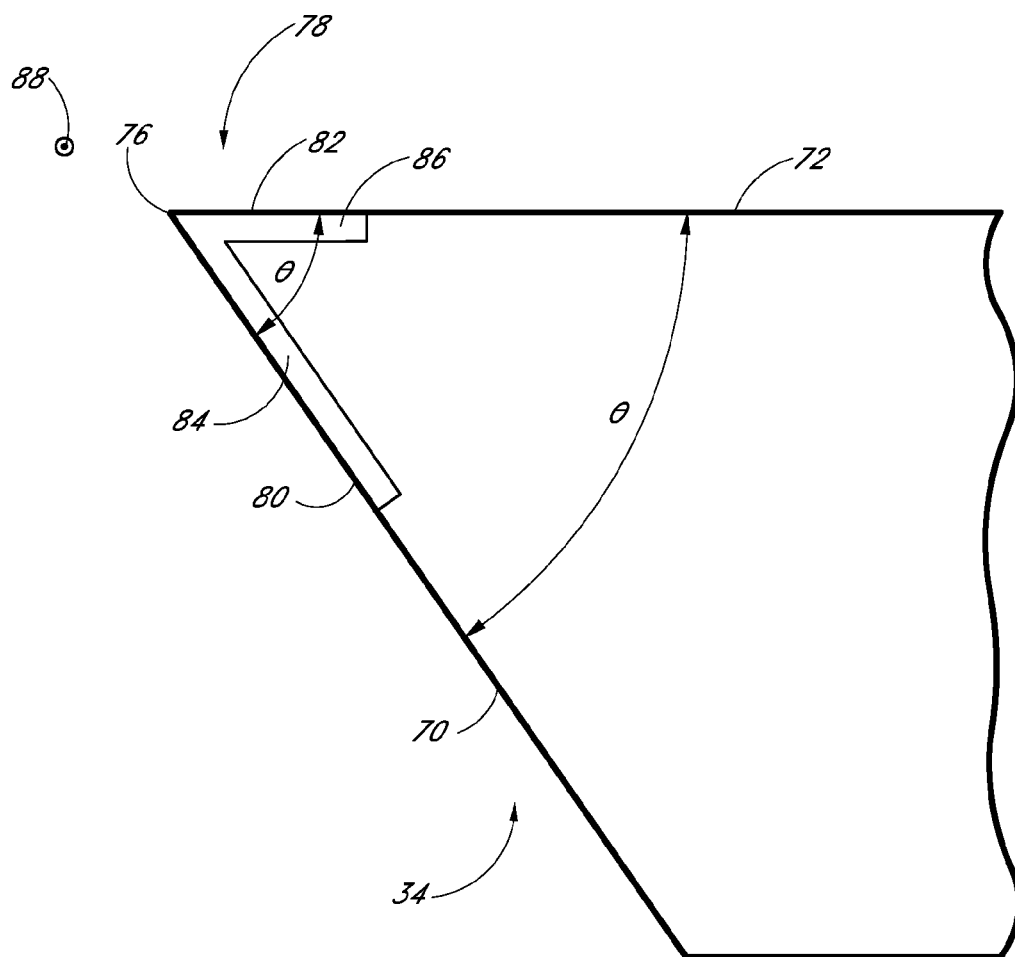


FIG. 9

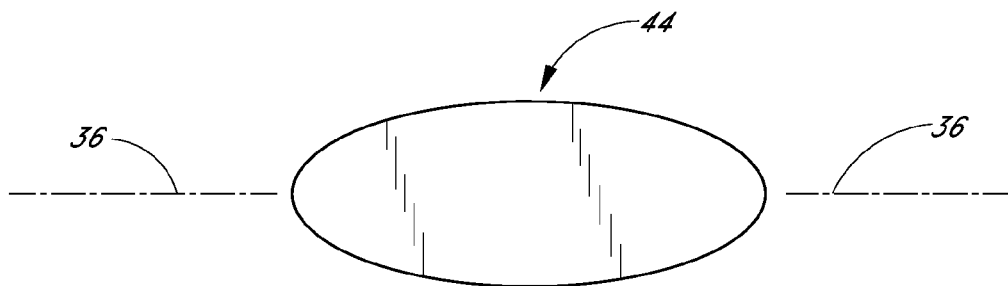


FIG. 10

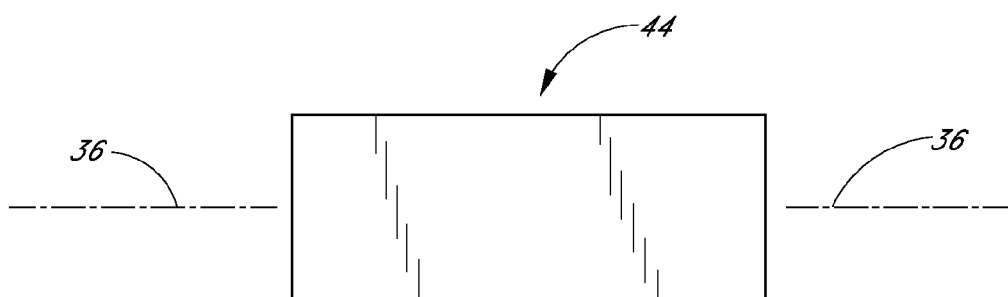


FIG. 11

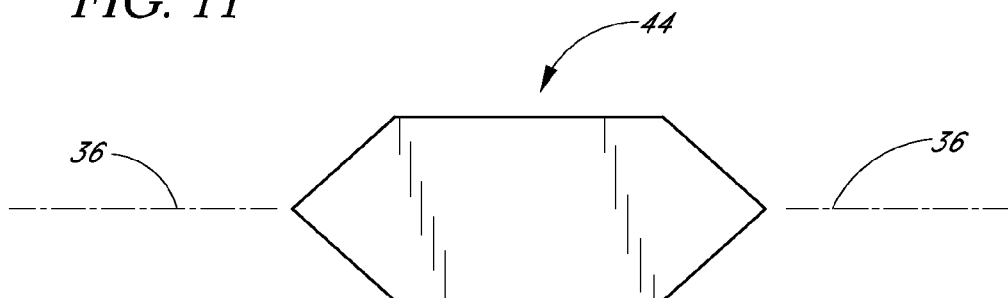


FIG. 12

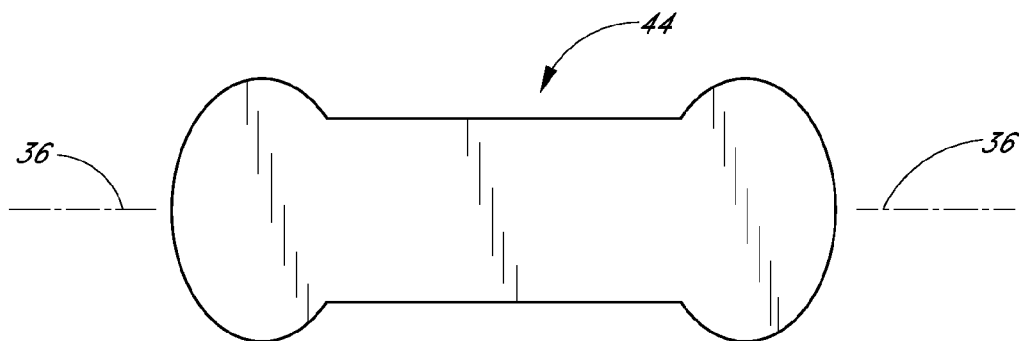


FIG. 13

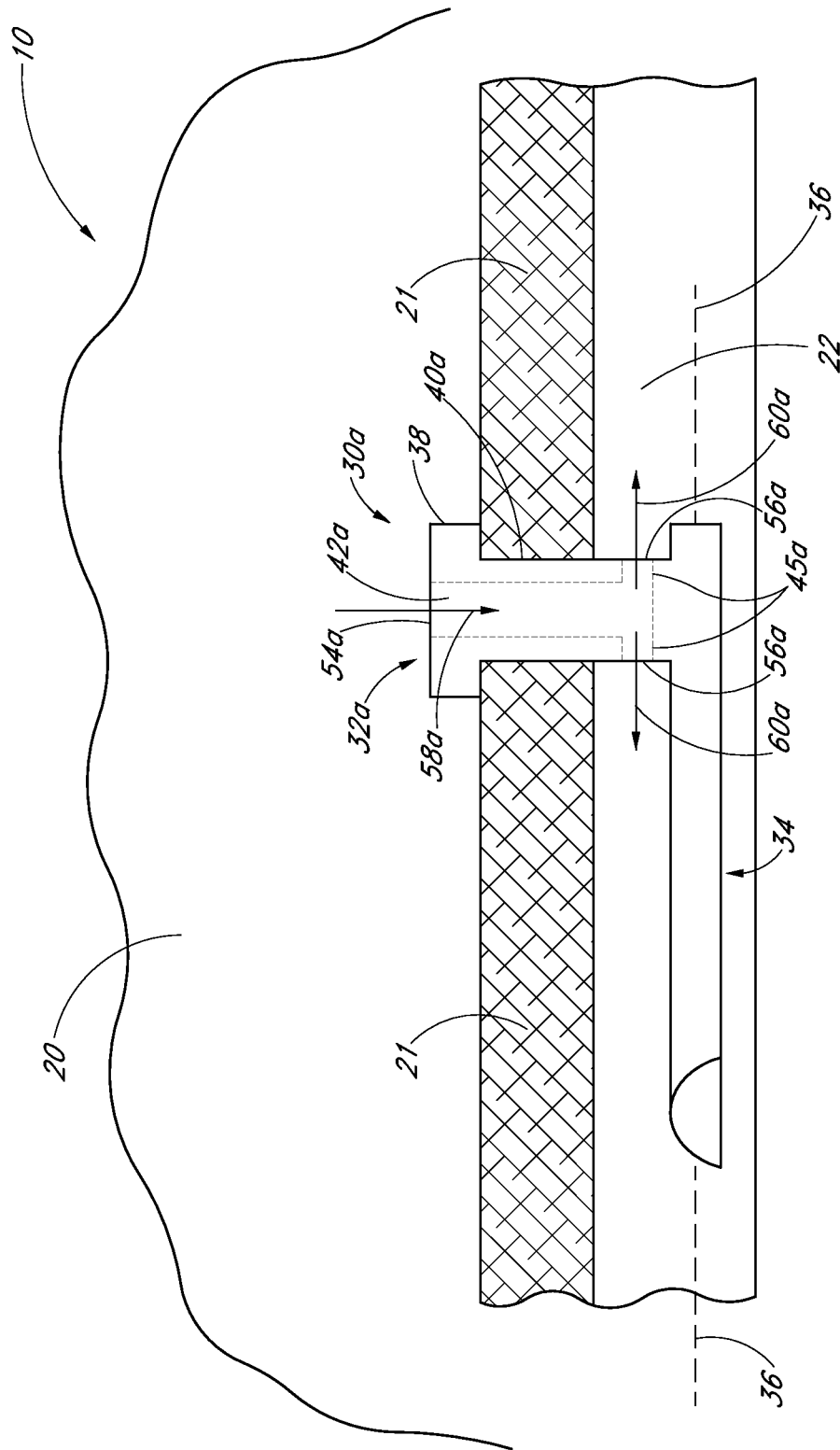
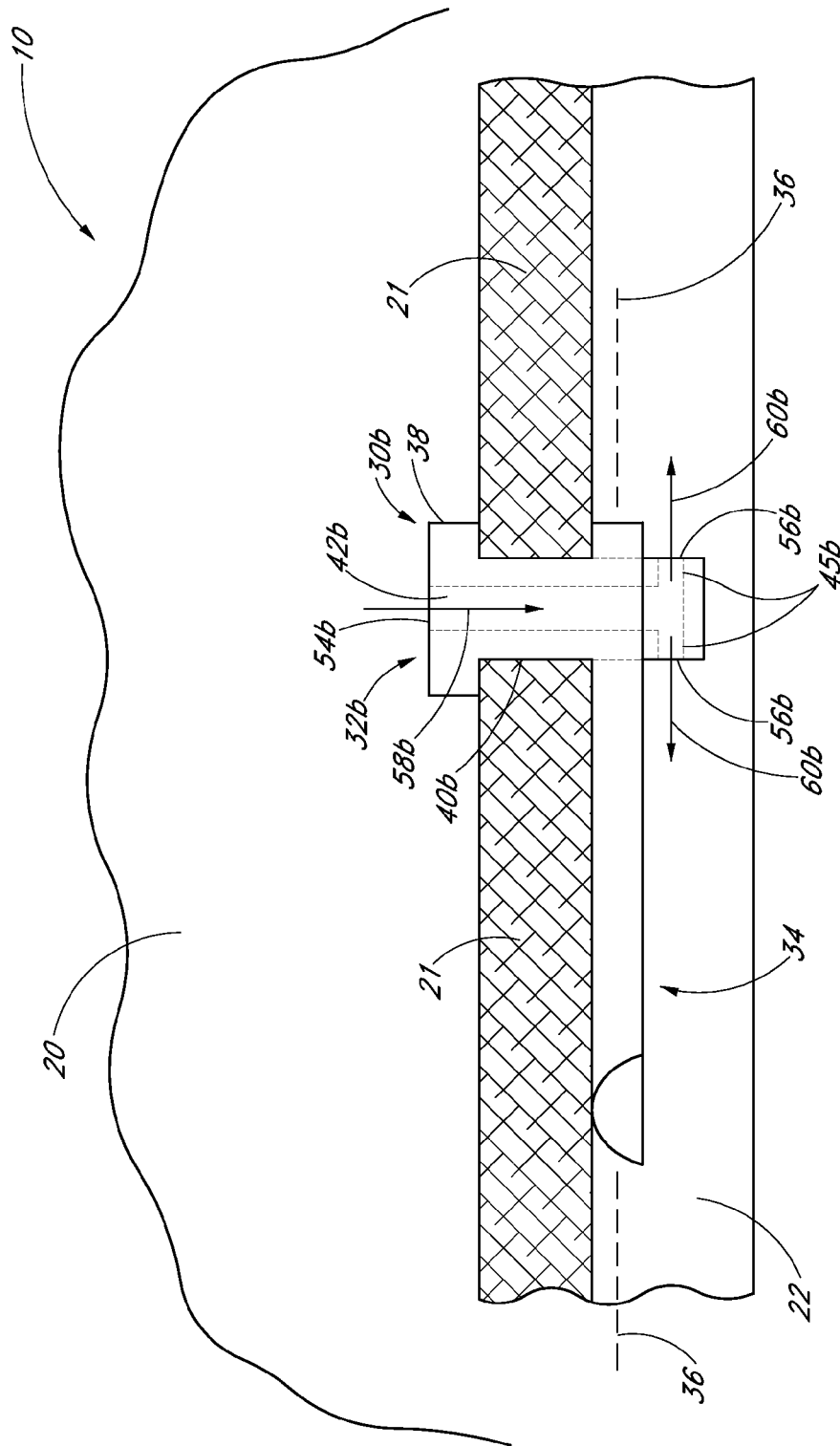
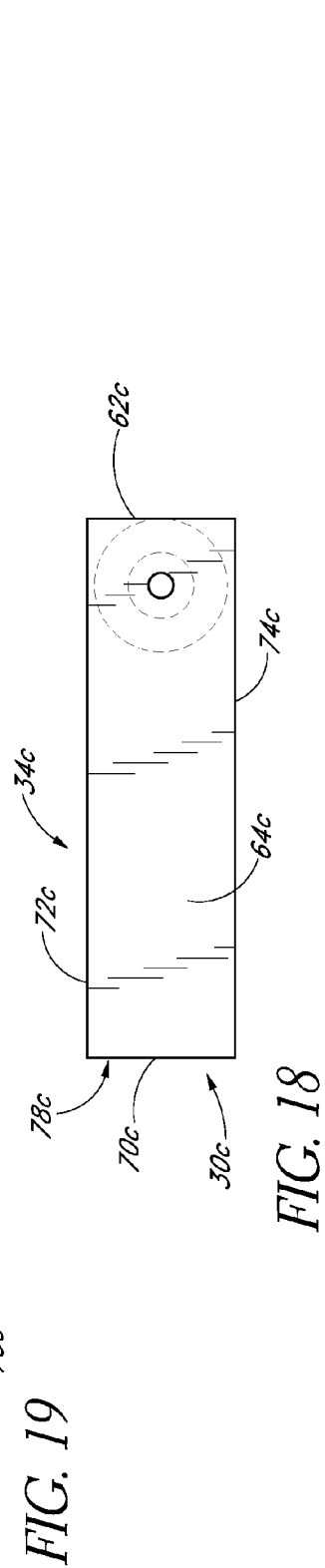
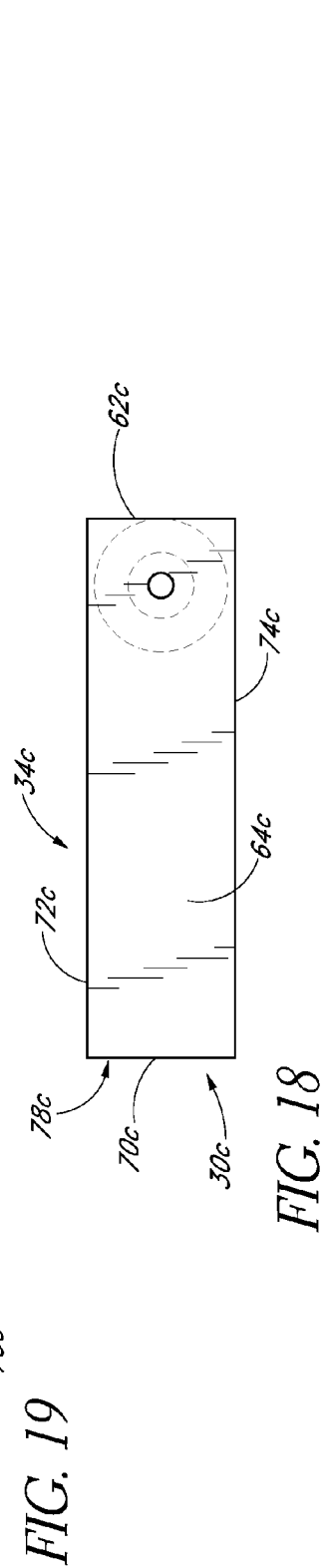
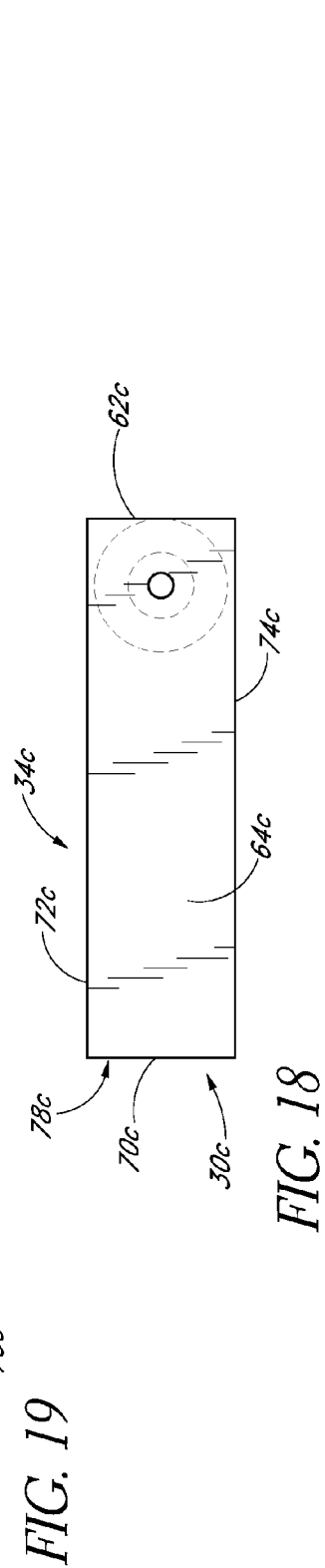
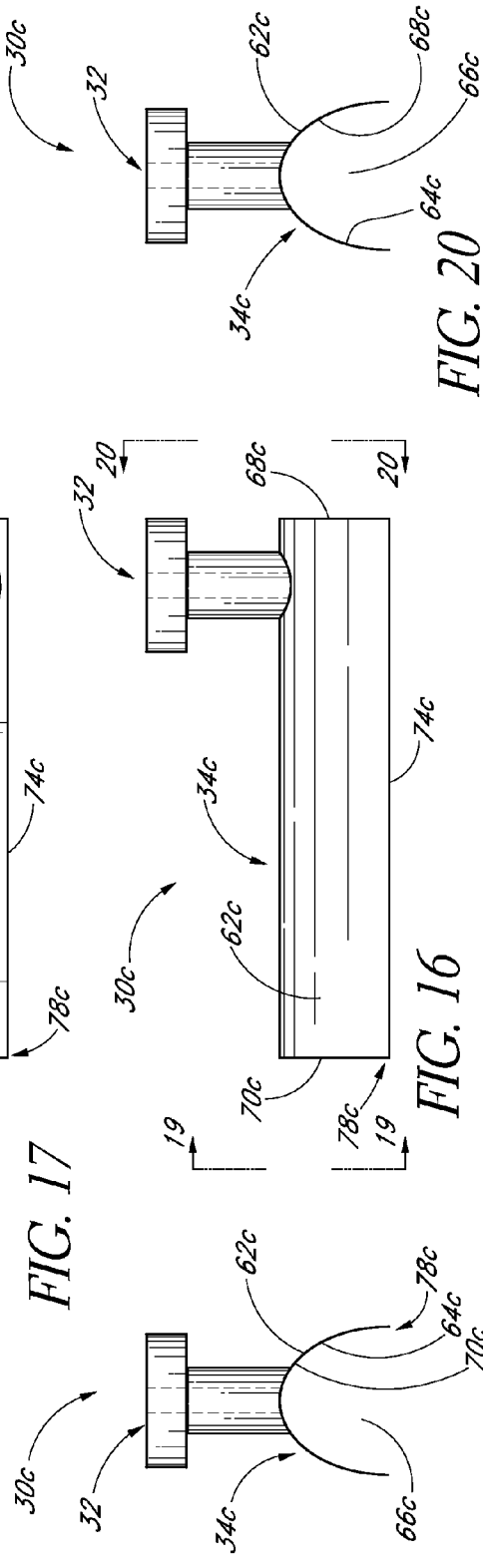
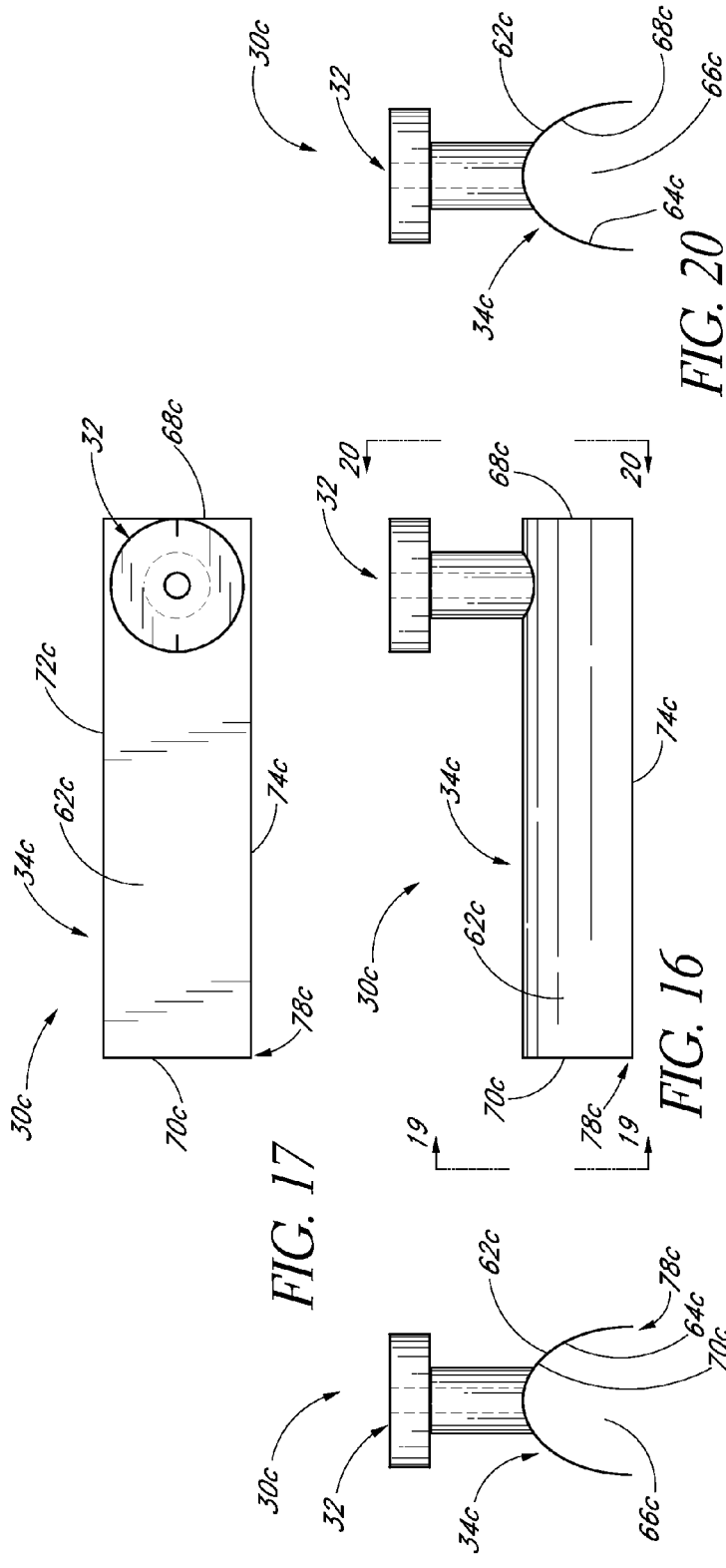


FIG. 14



**FIG. 15**



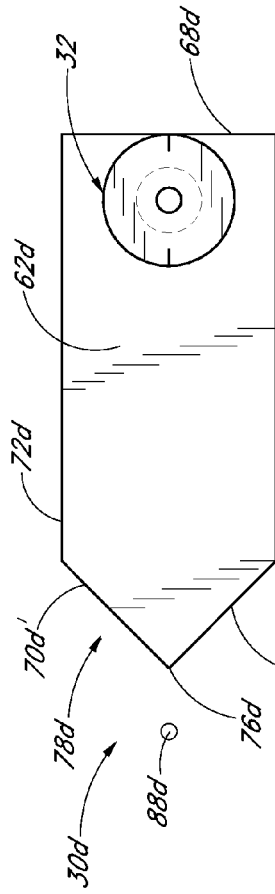


FIG. 22

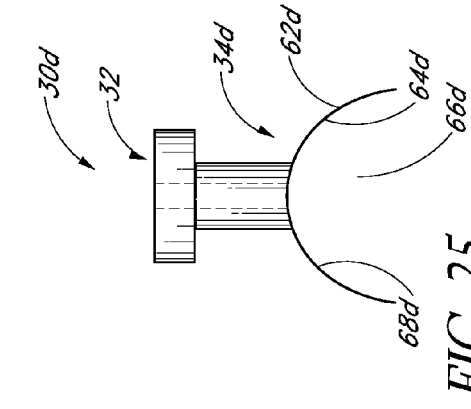


FIG. 25

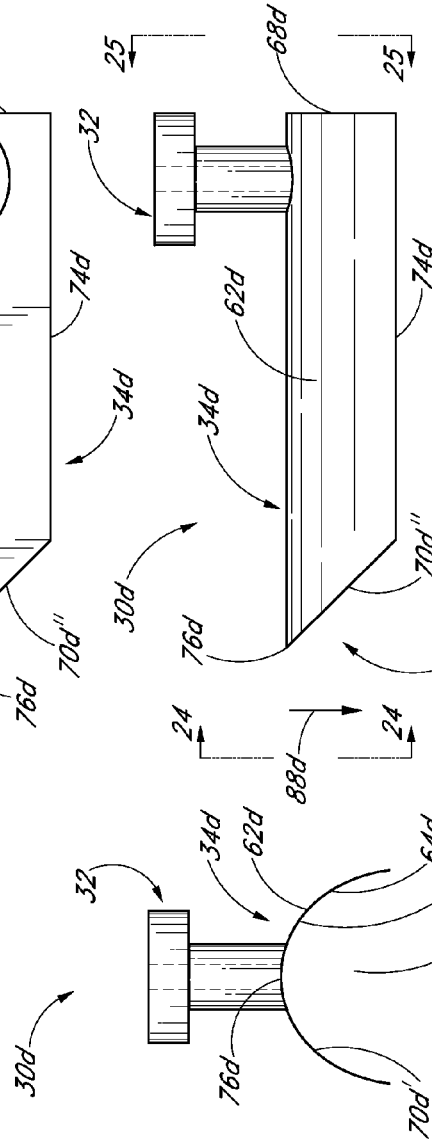


FIG. 21

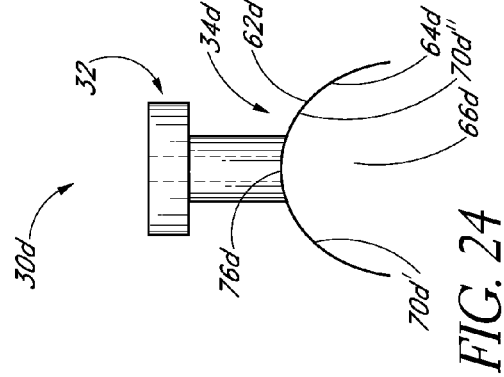


FIG. 24

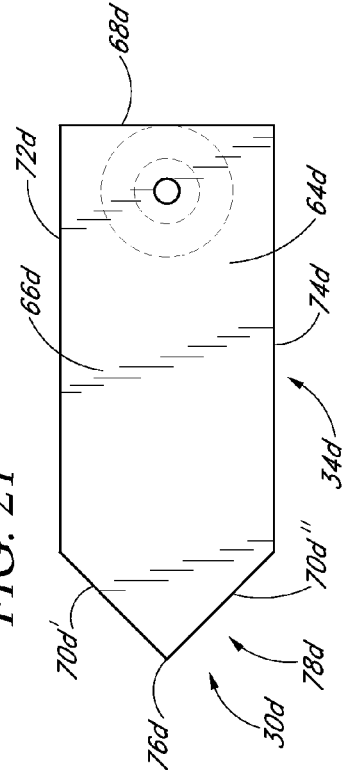


FIG. 23

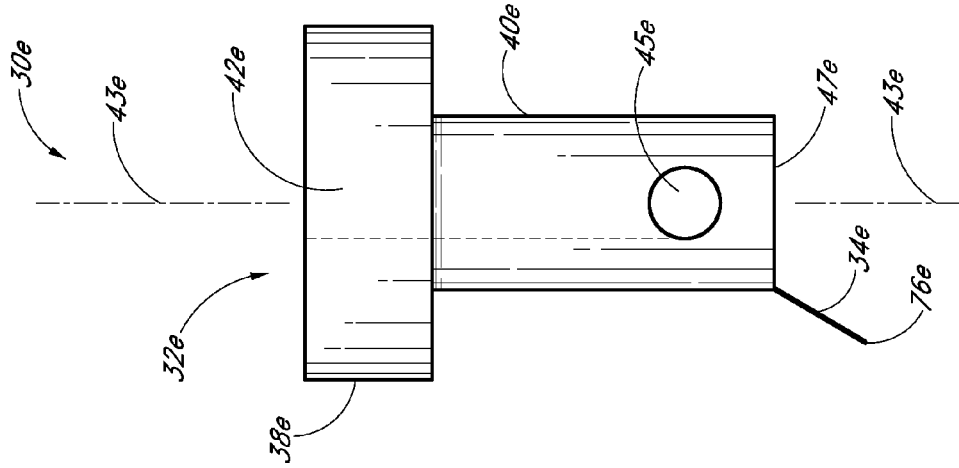


FIG. 26

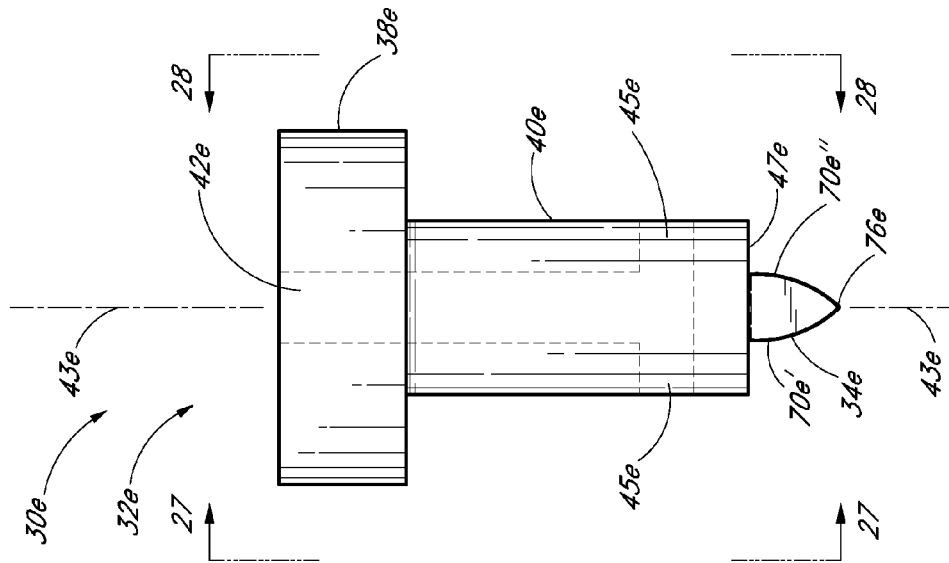


FIG. 27

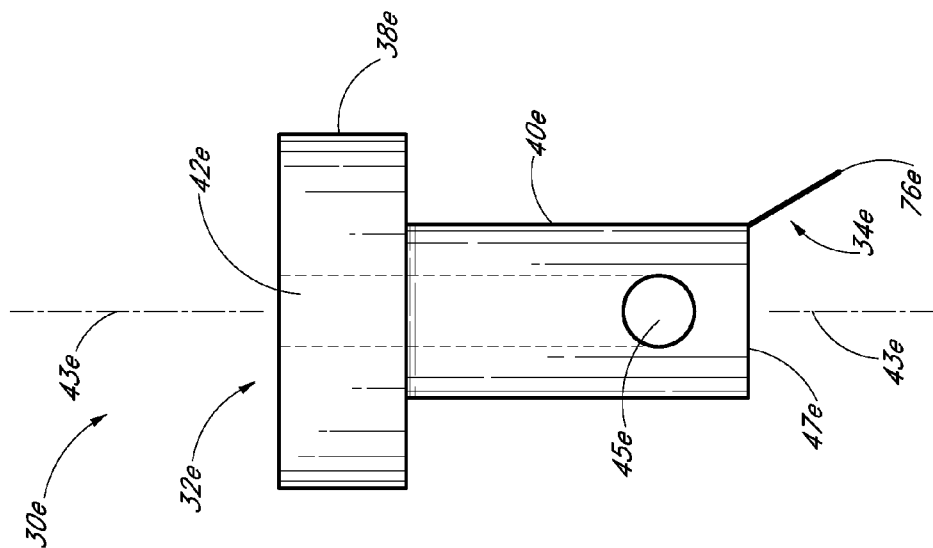
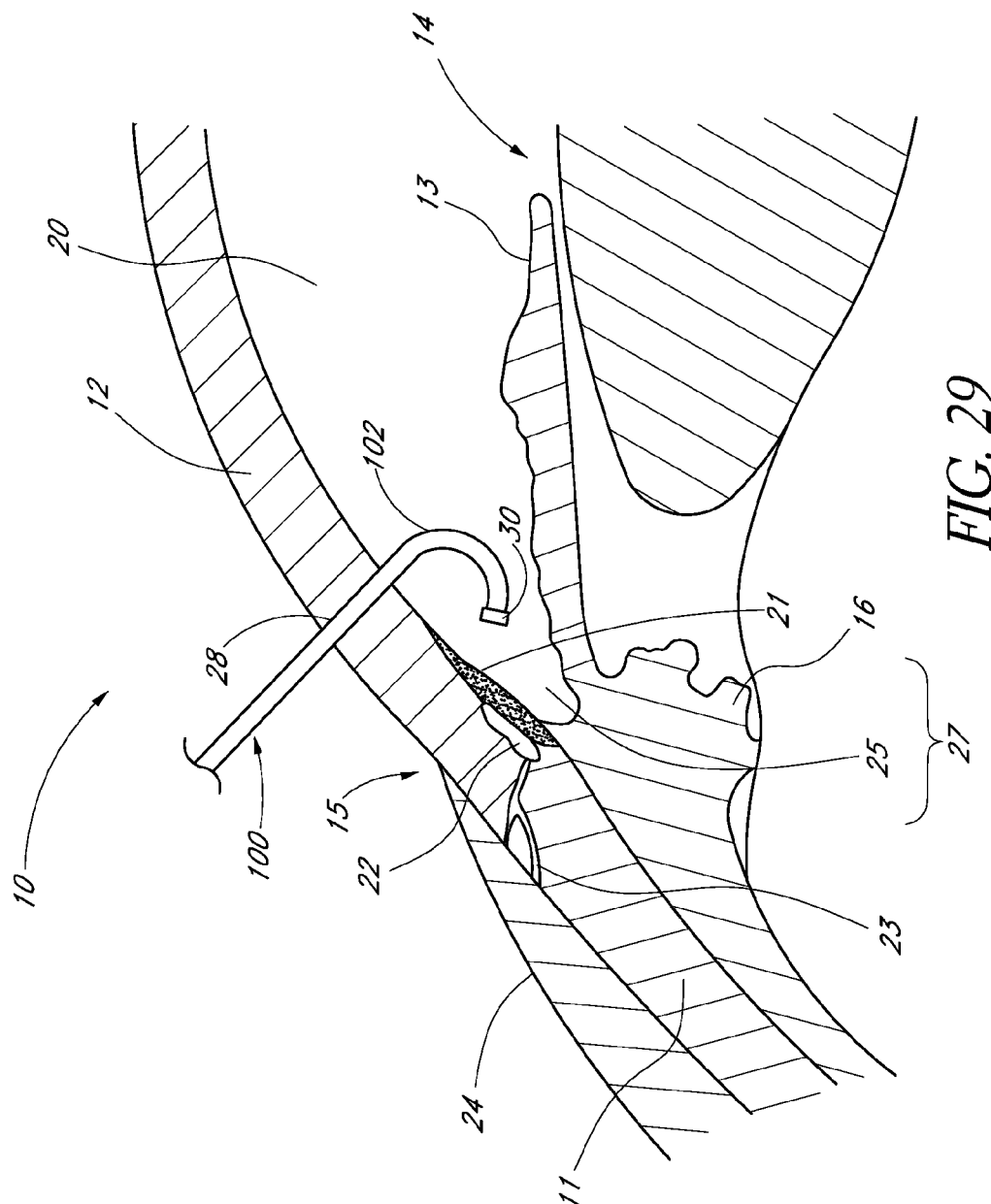
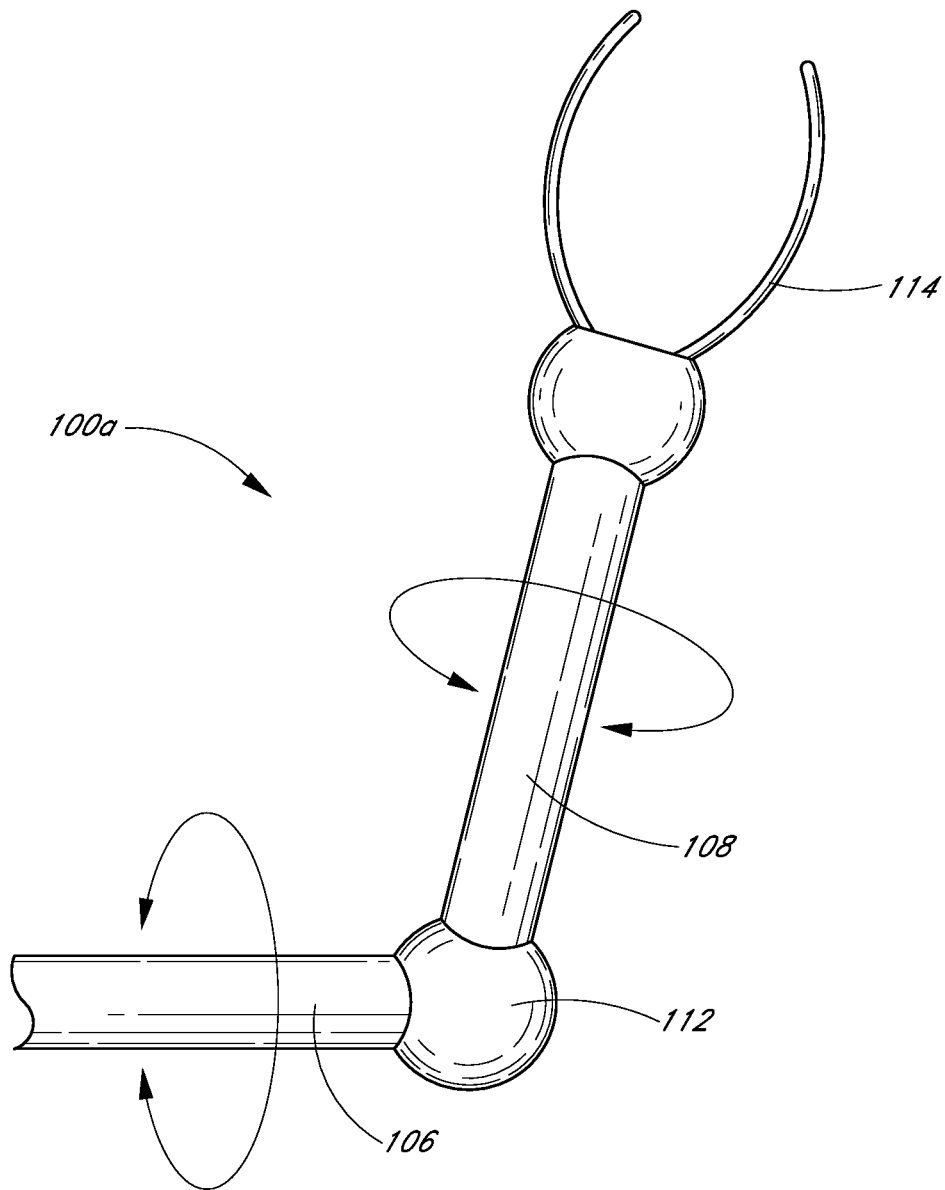


FIG. 28





*FIG. 30*

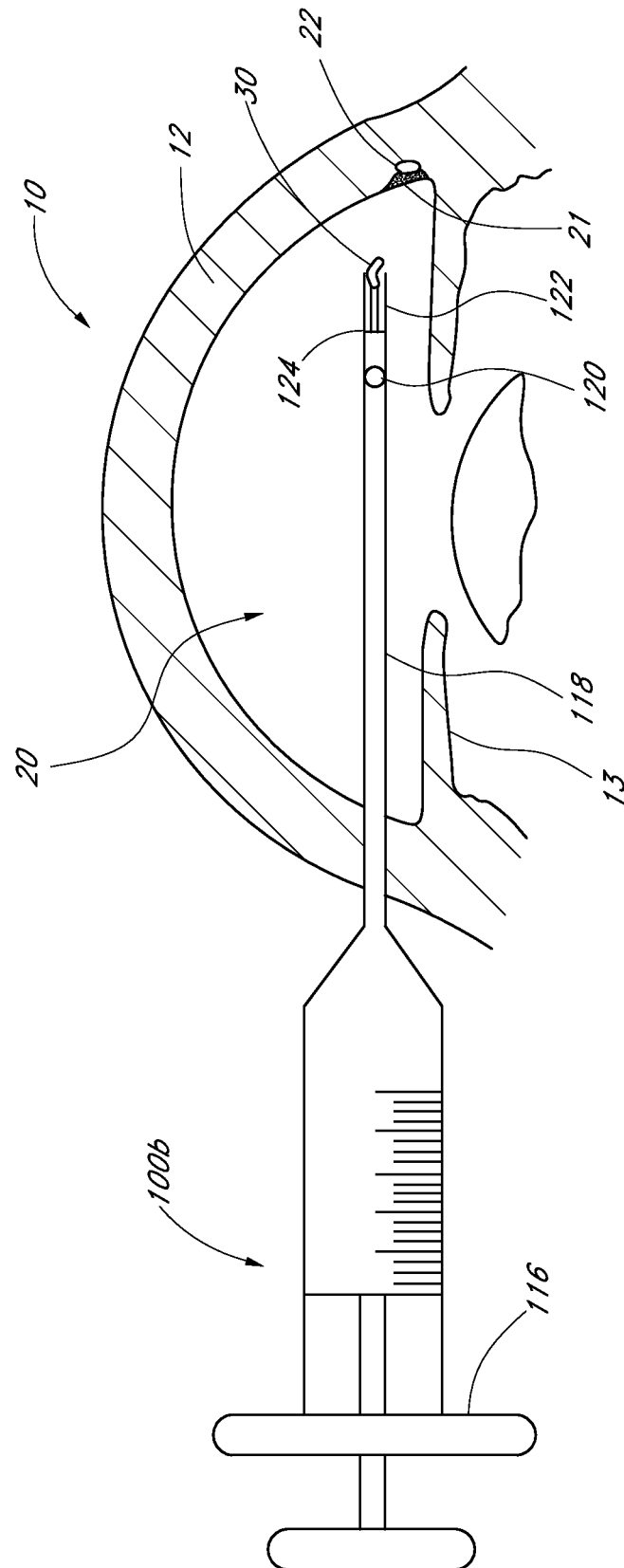


FIG. 31

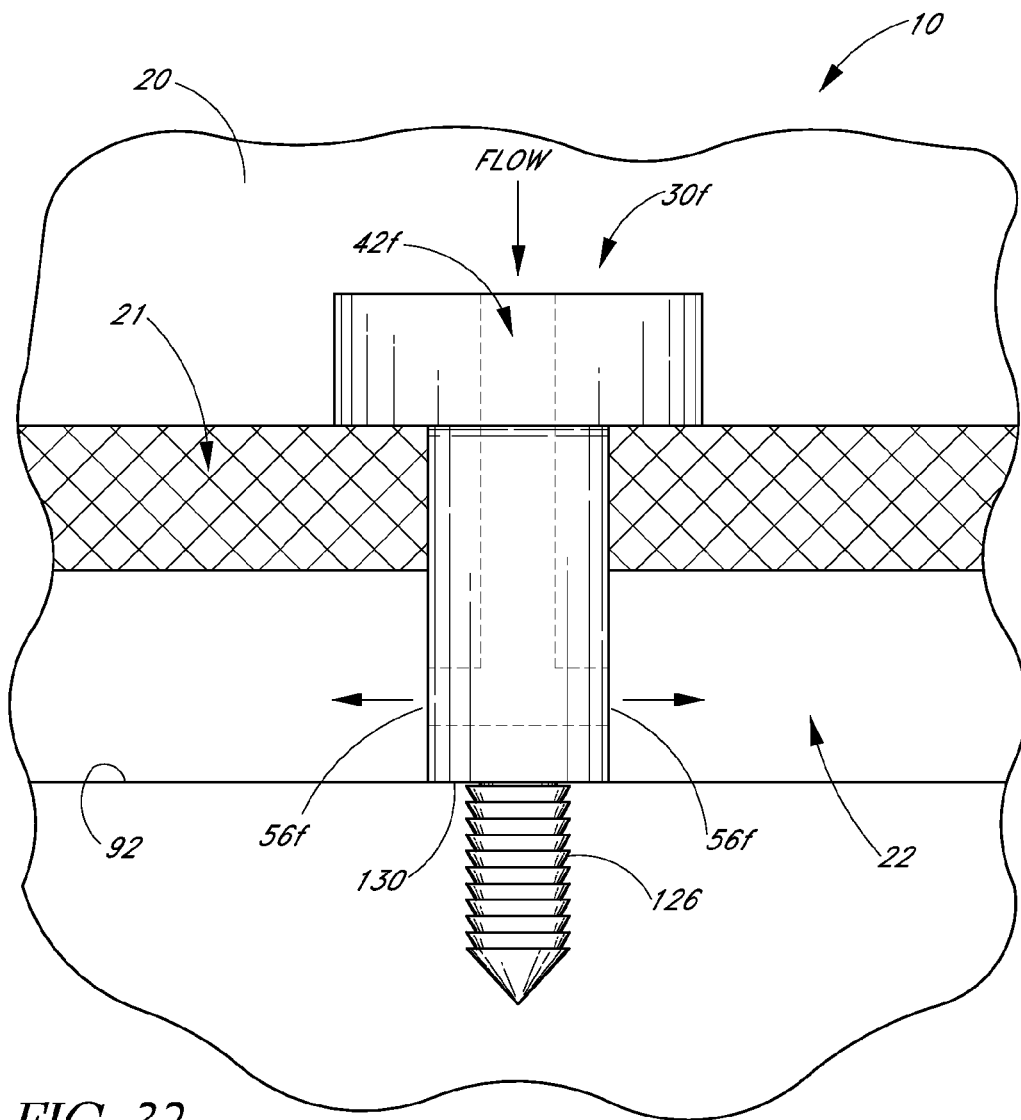


FIG. 32

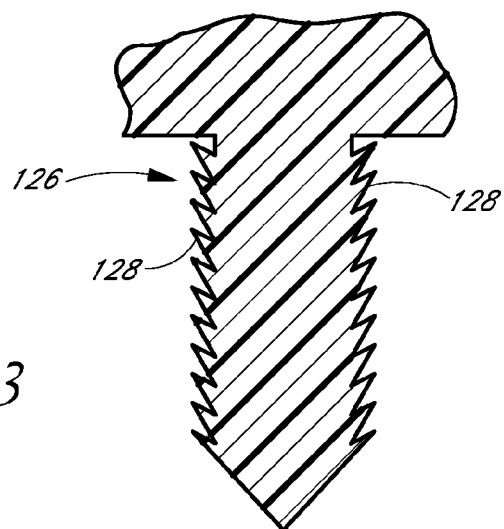
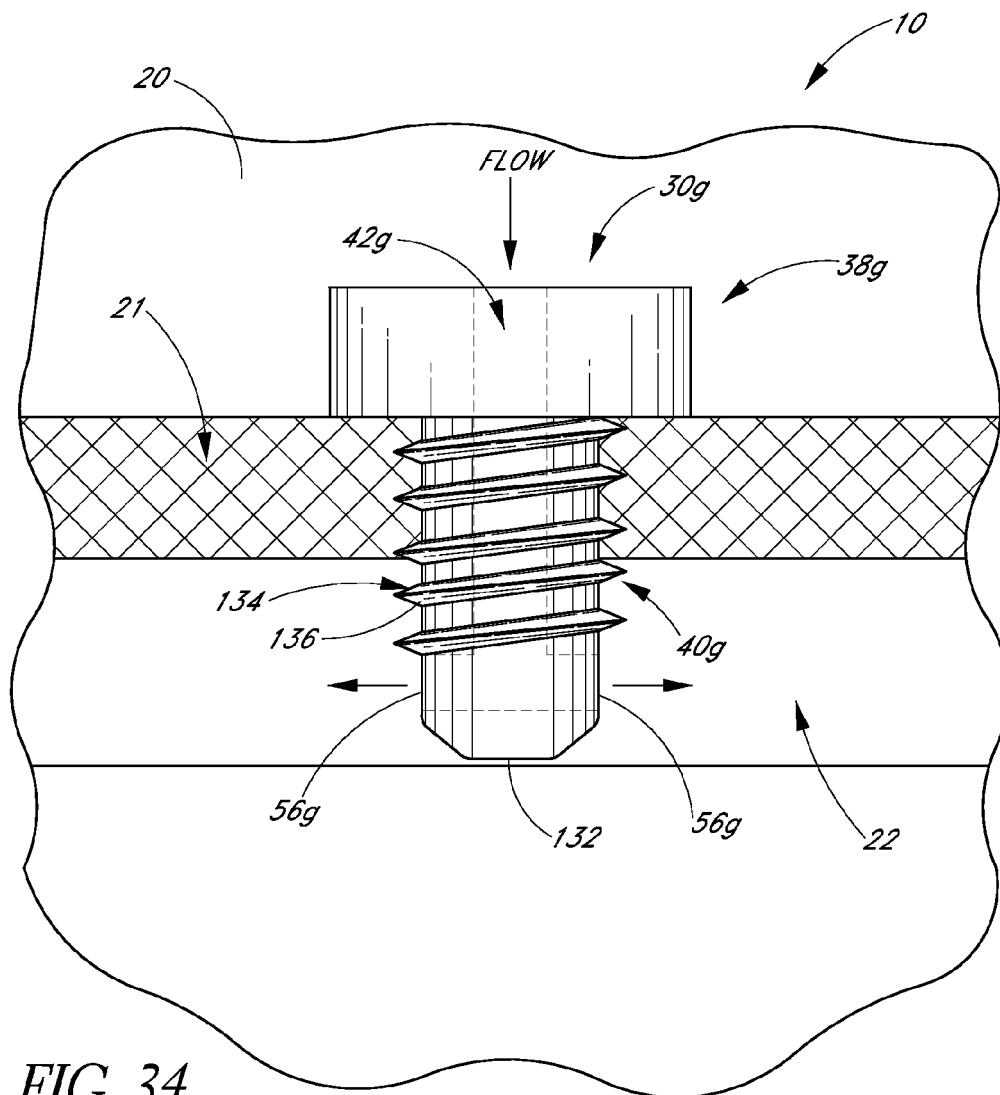


FIG. 33



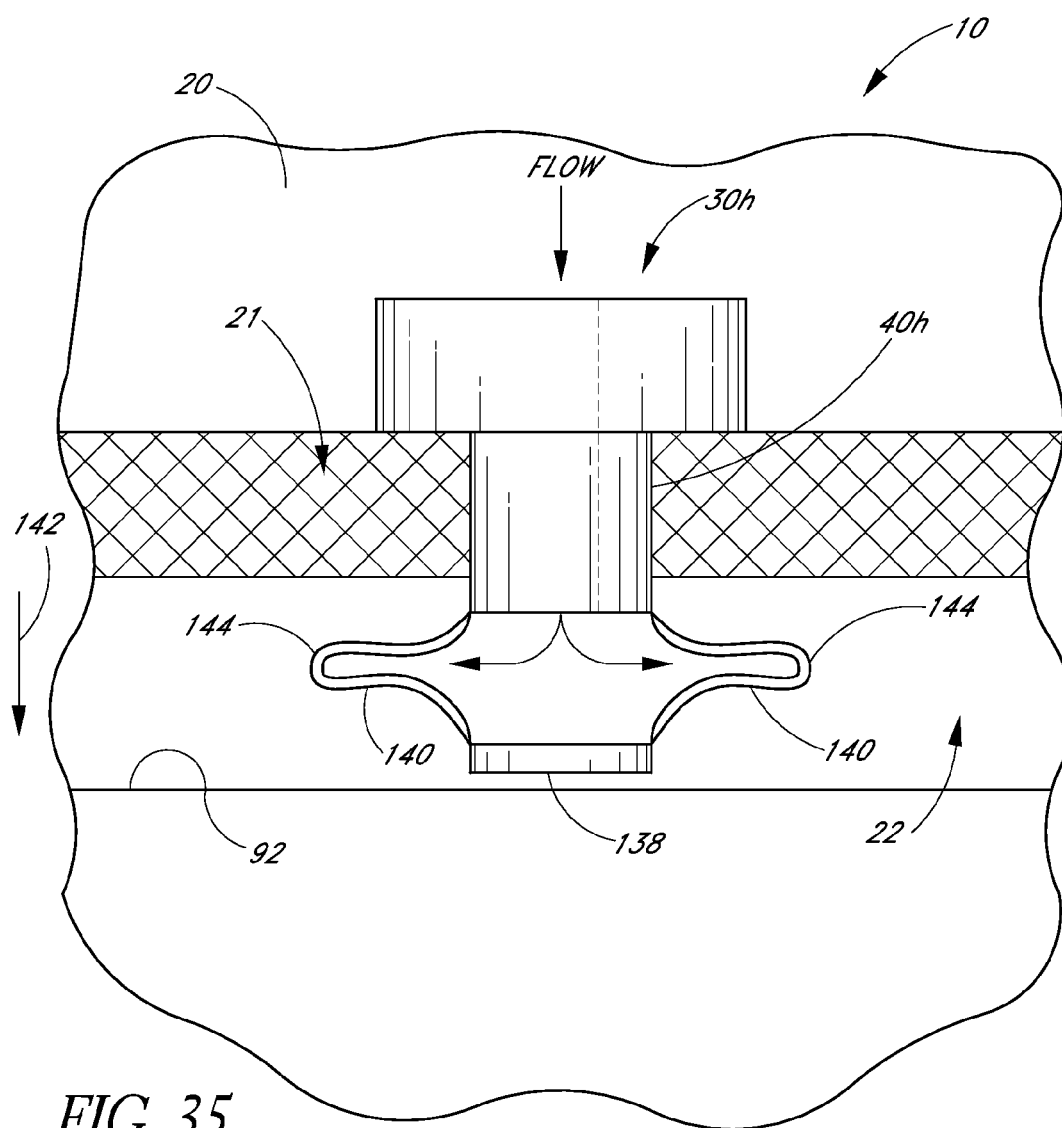


FIG. 35

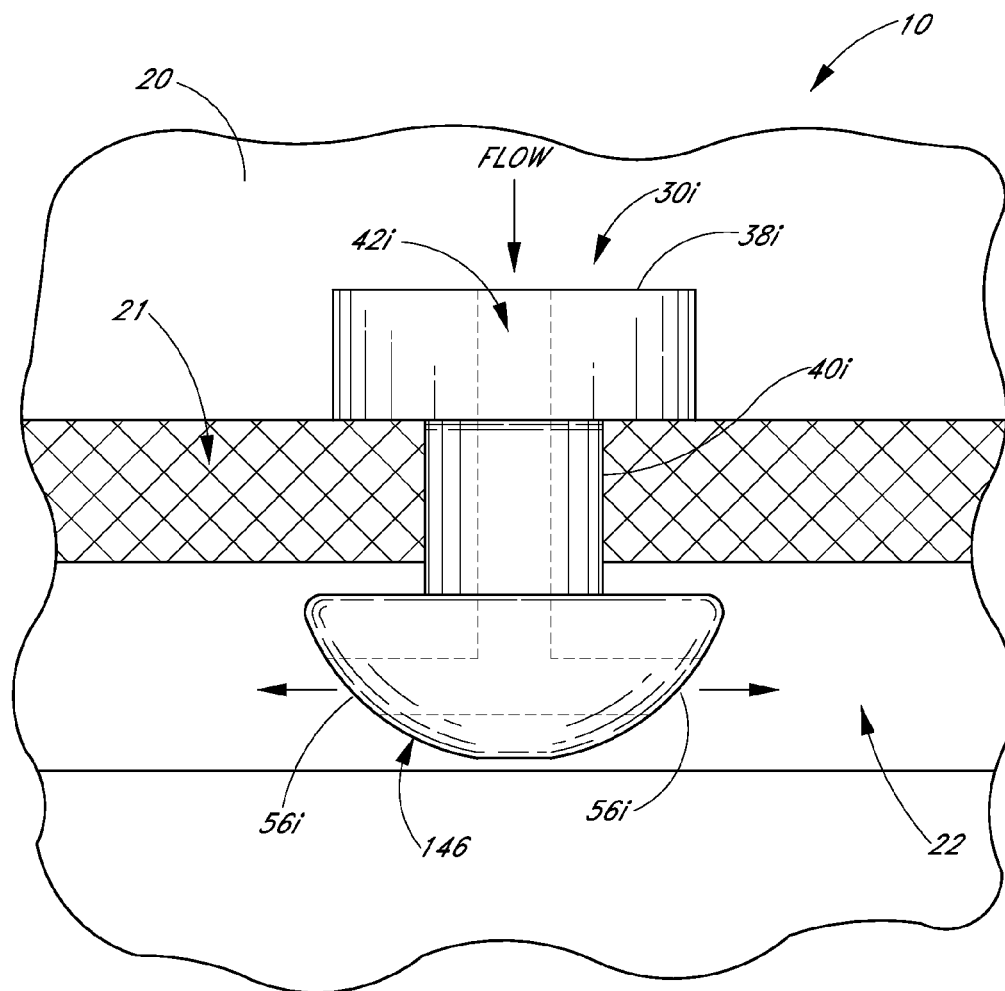


FIG. 36

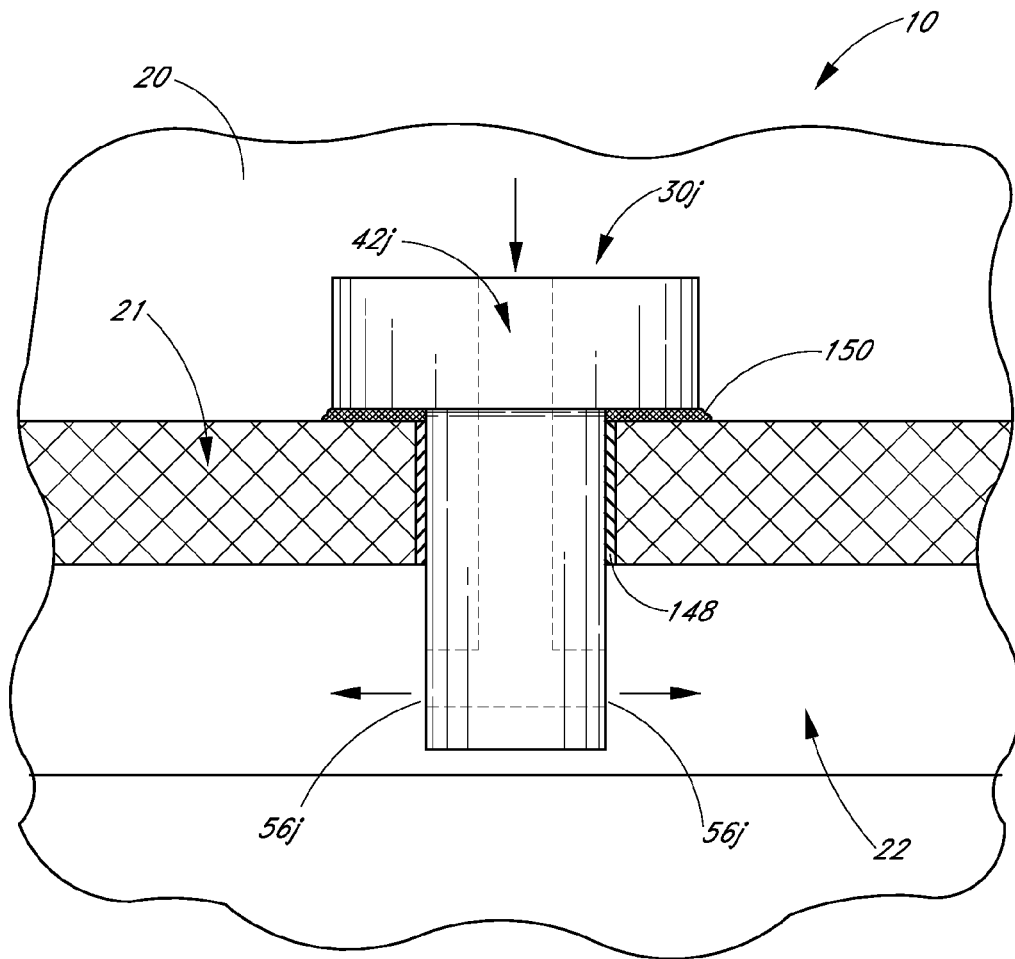


FIG. 37



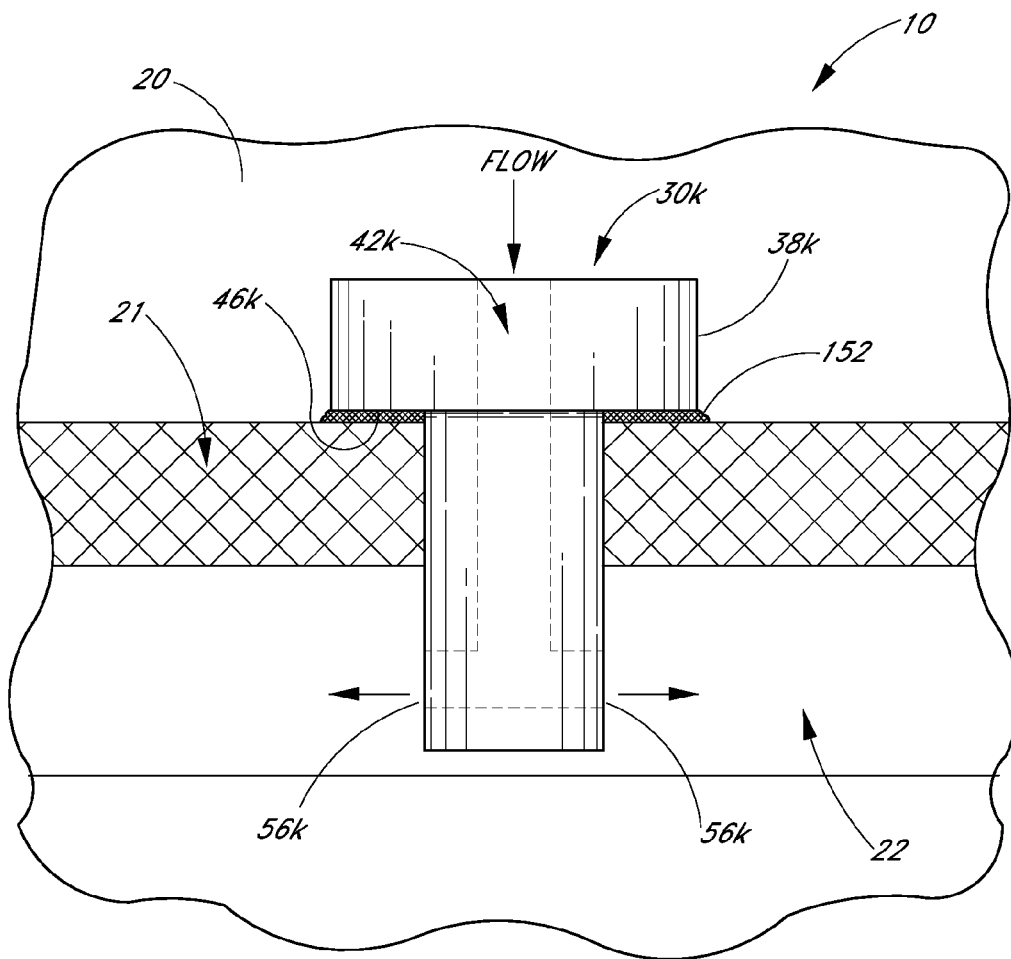


FIG. 38

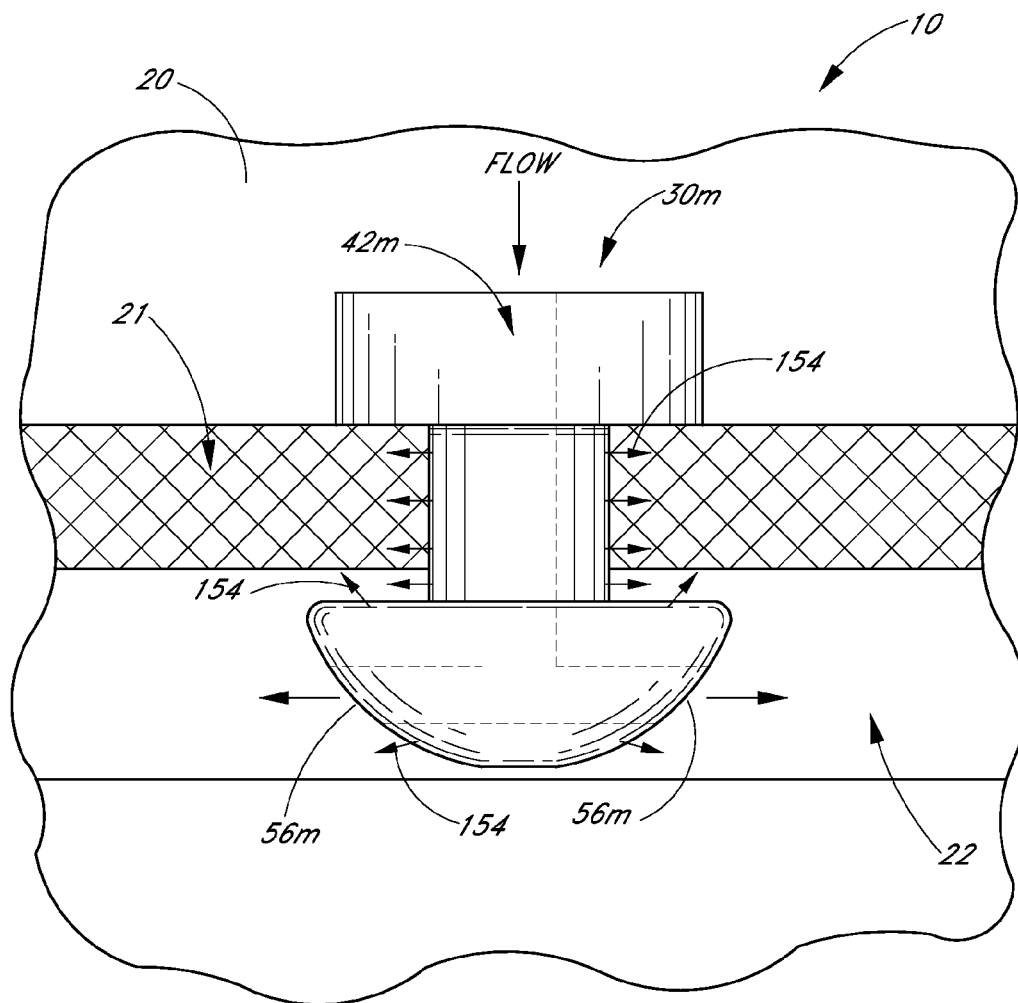


FIG. 39

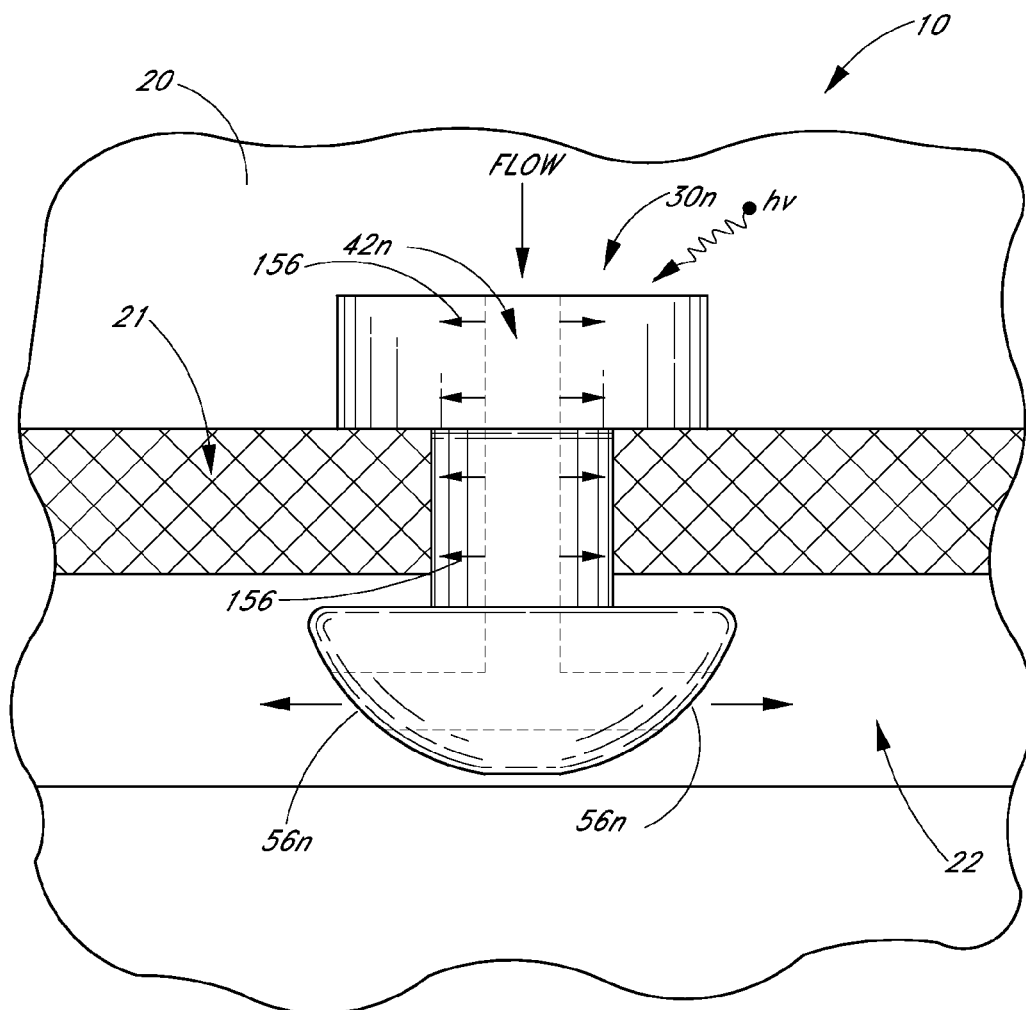


FIG. 40

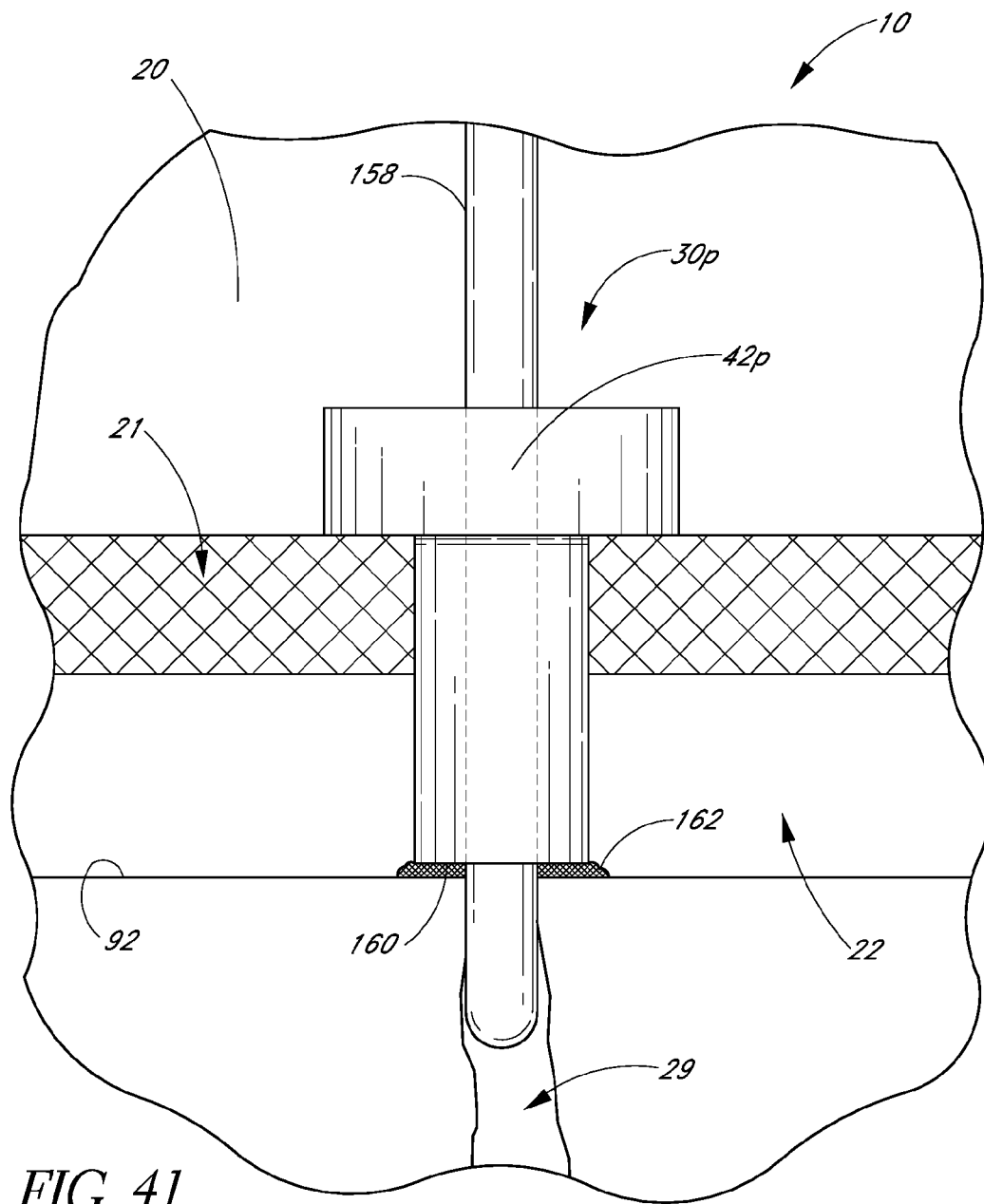


FIG. 41

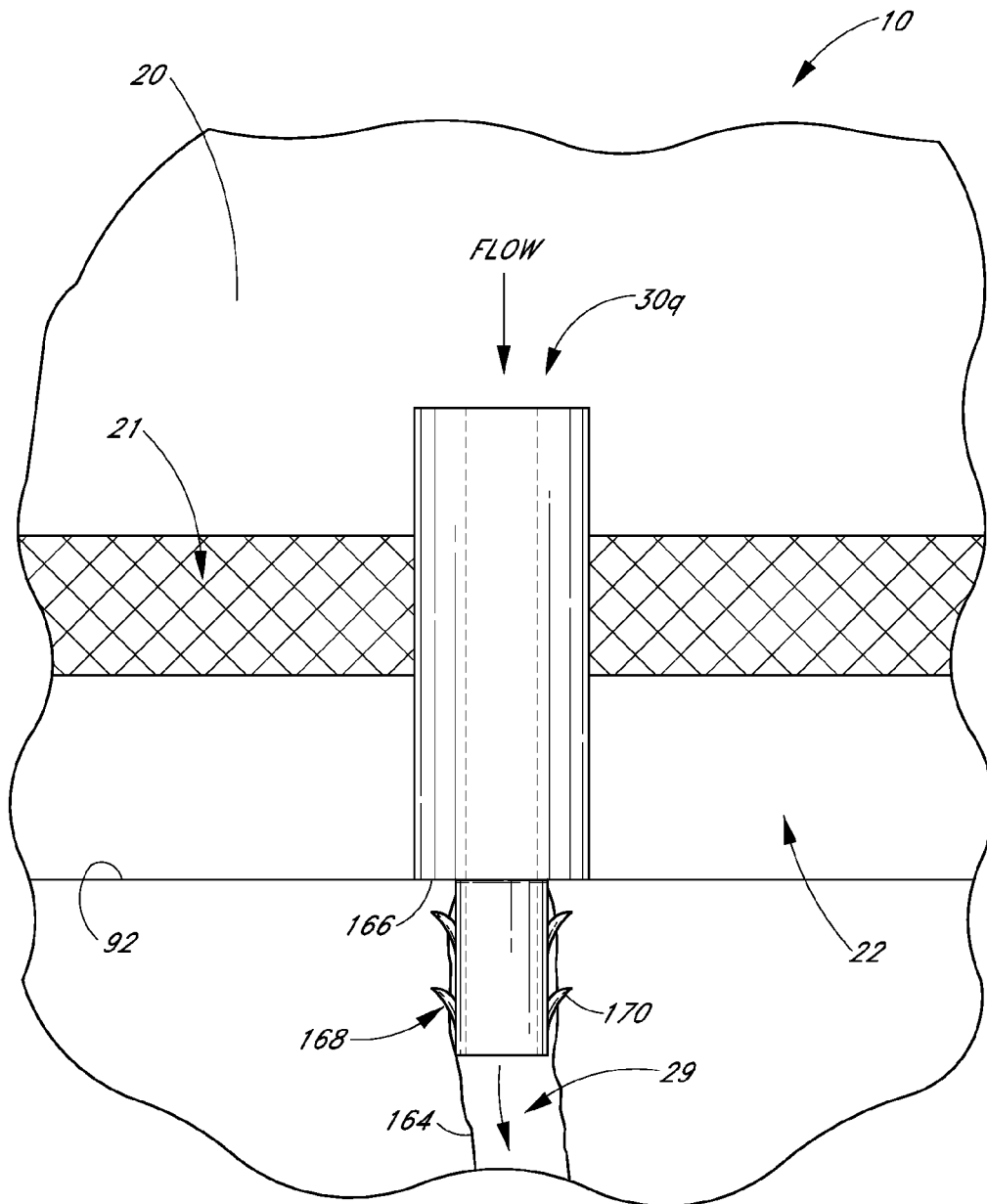
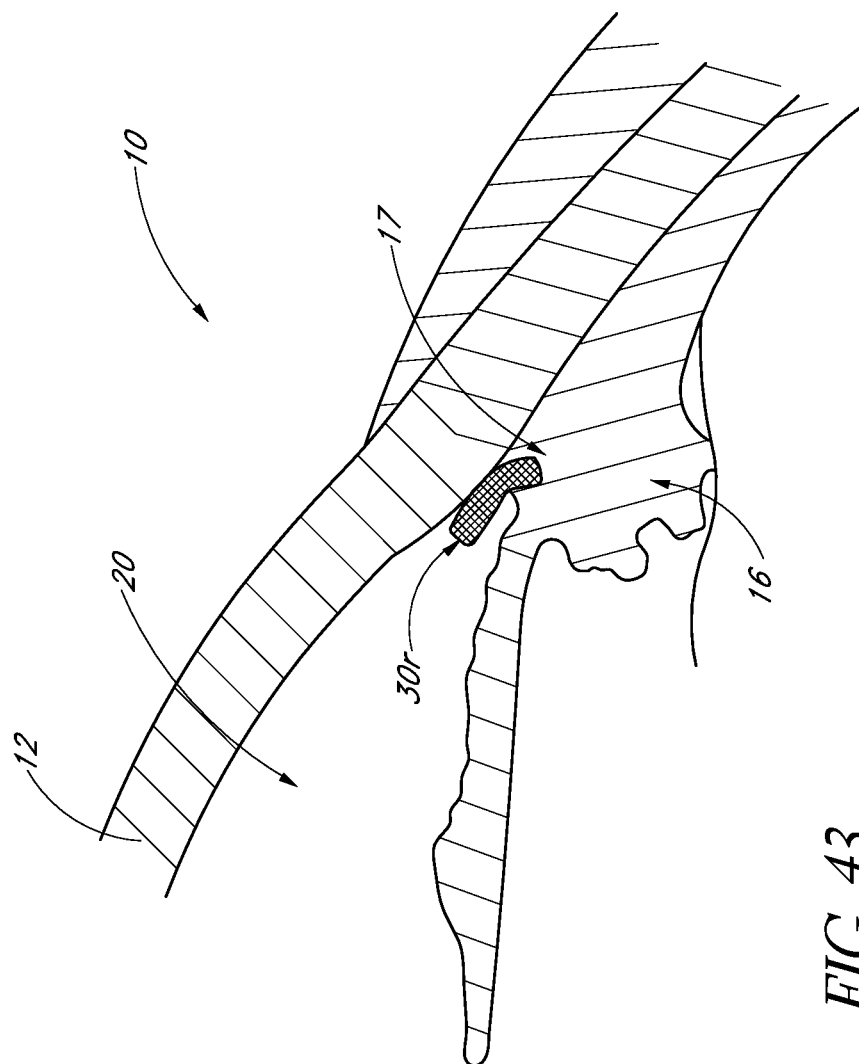
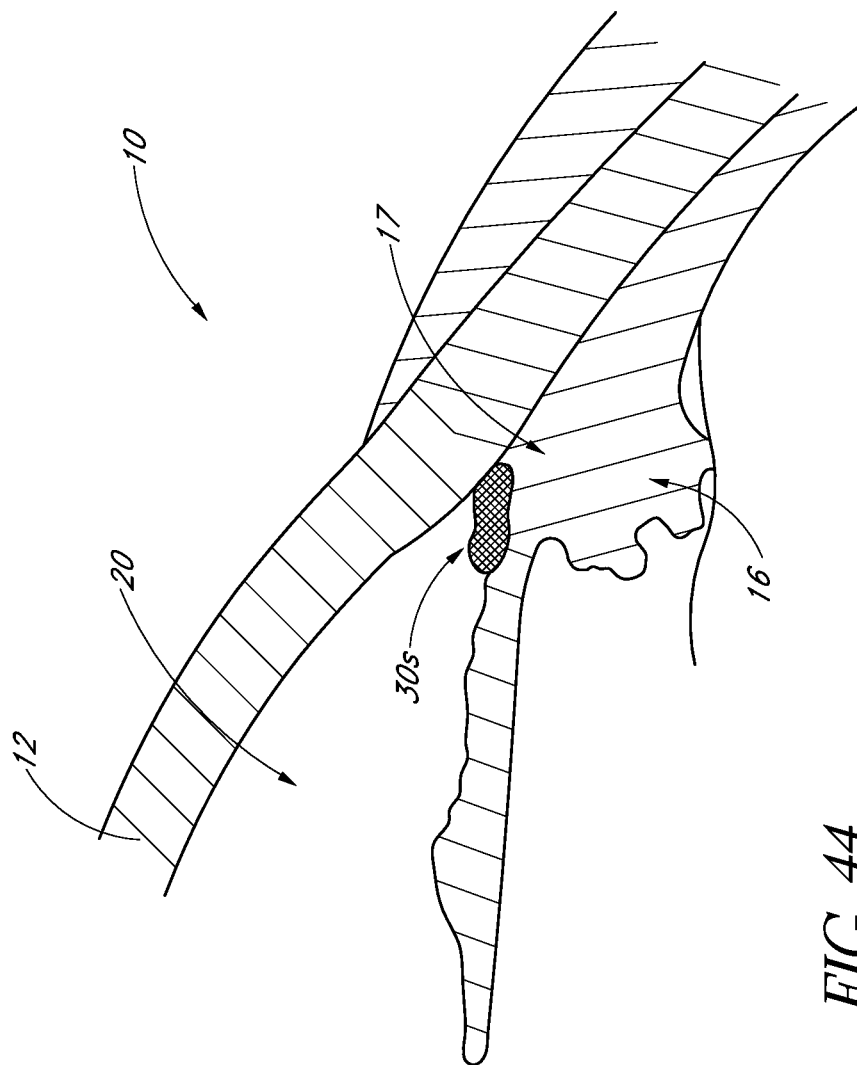
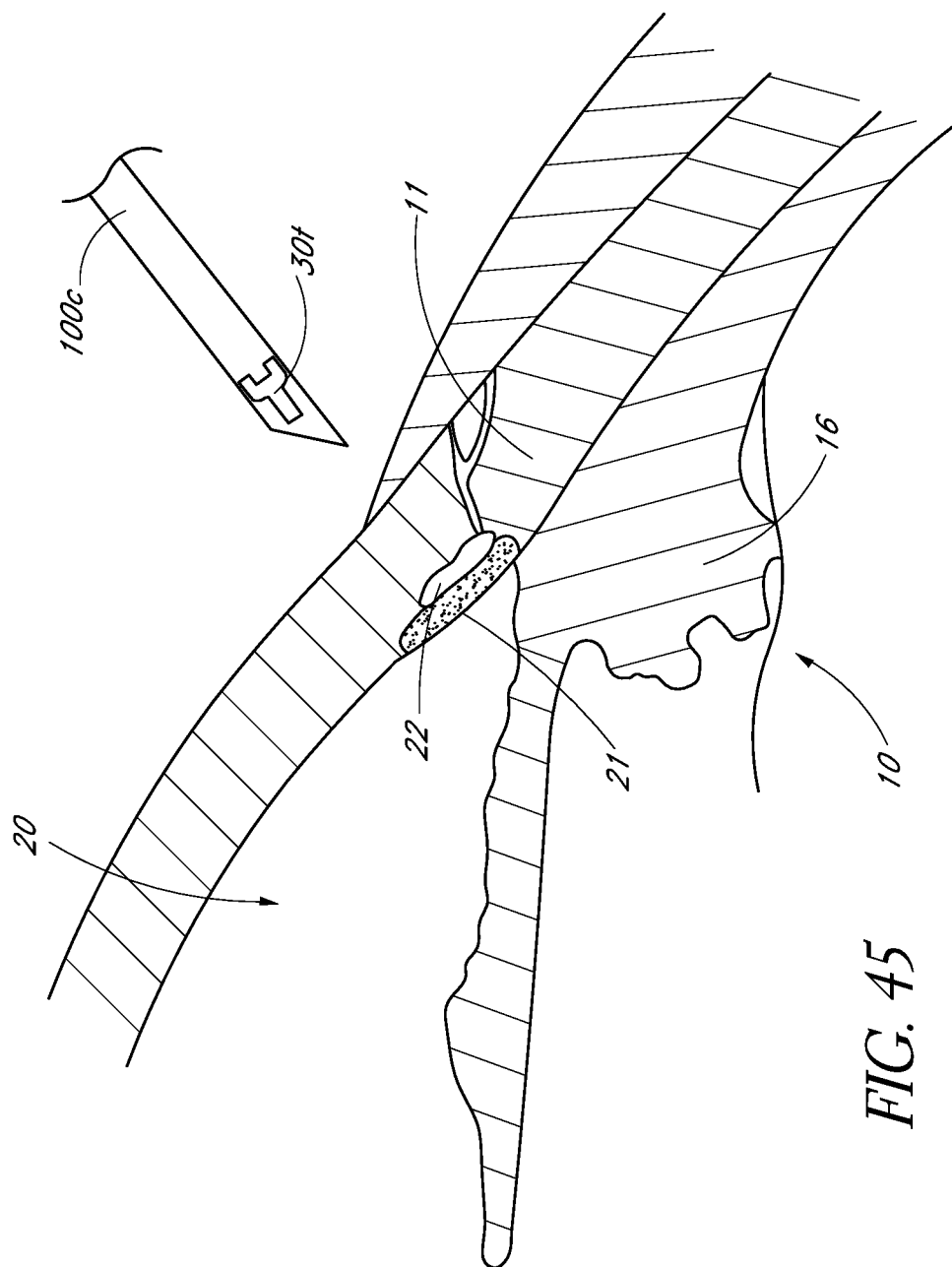


FIG. 42









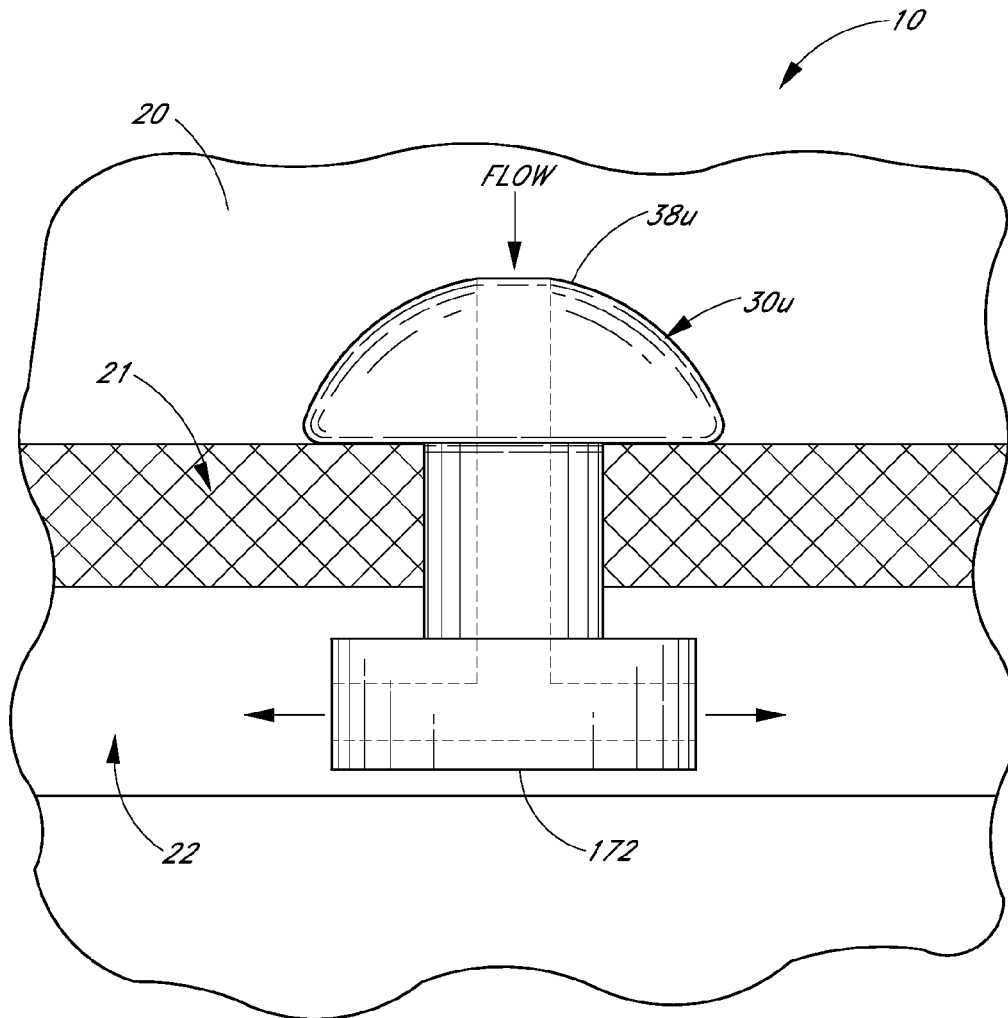
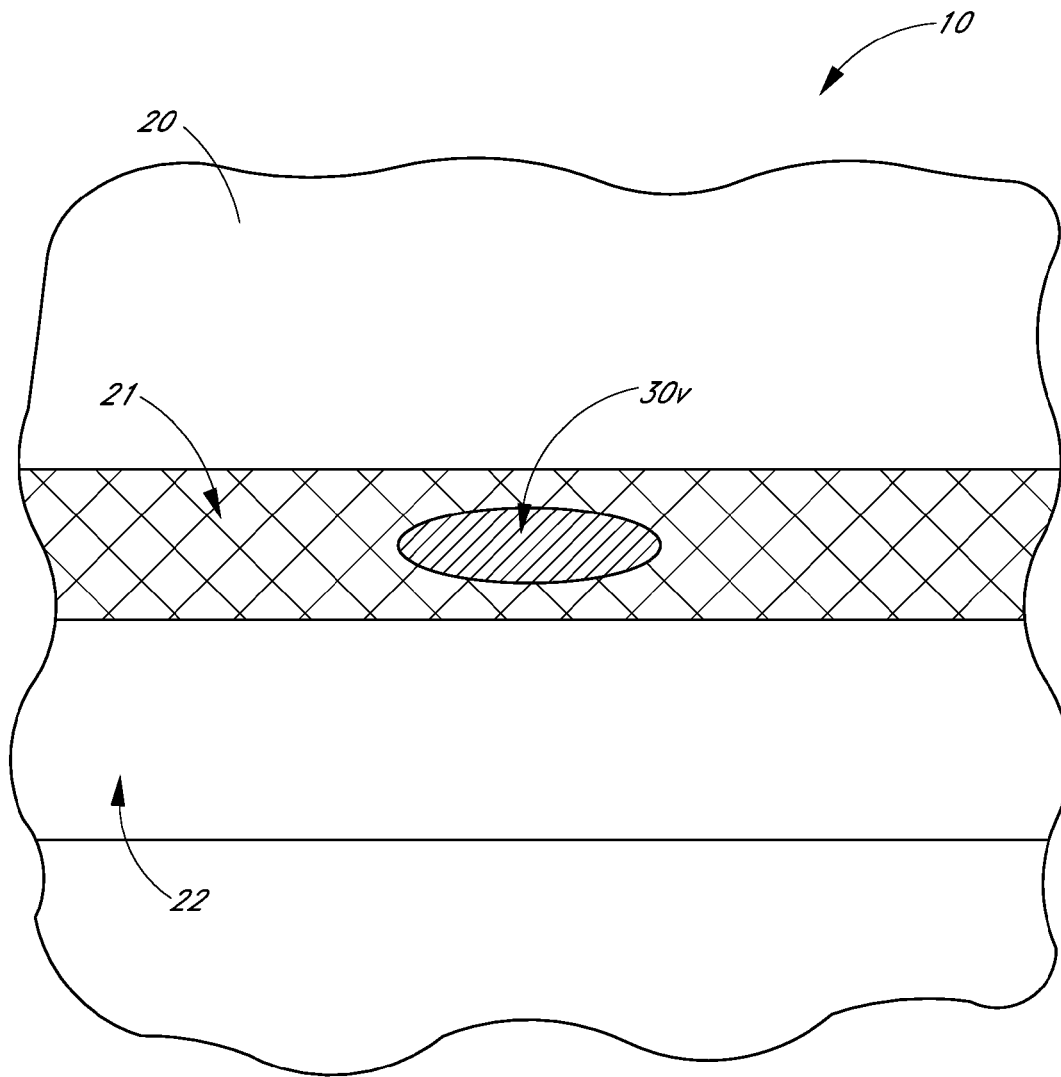


FIG. 46

*FIG. 47*

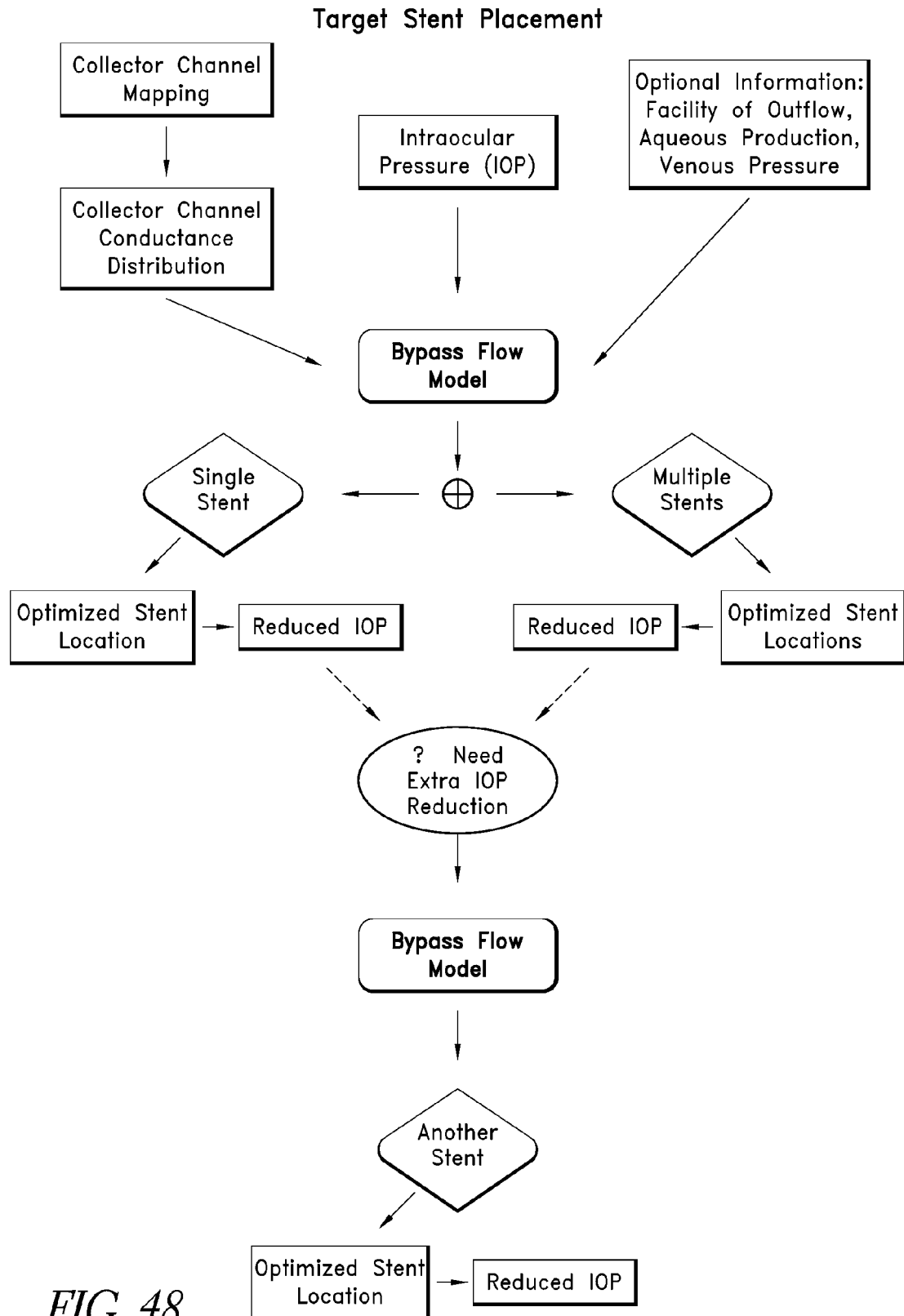


FIG. 48

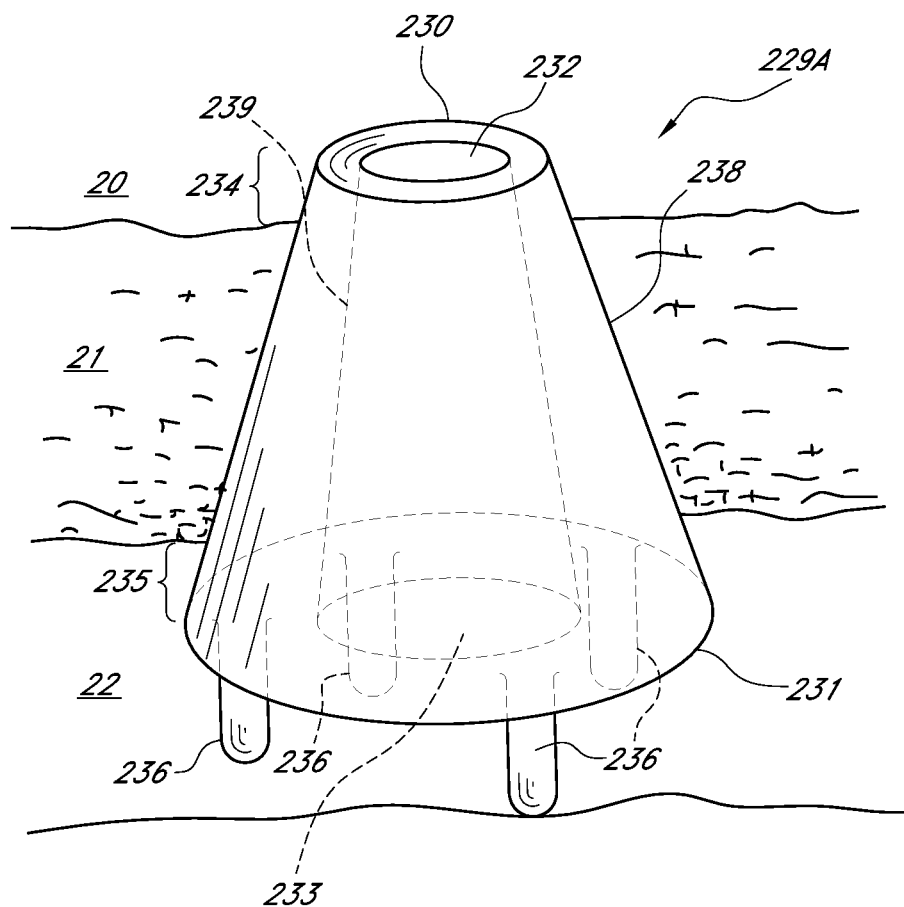


FIG. 49A

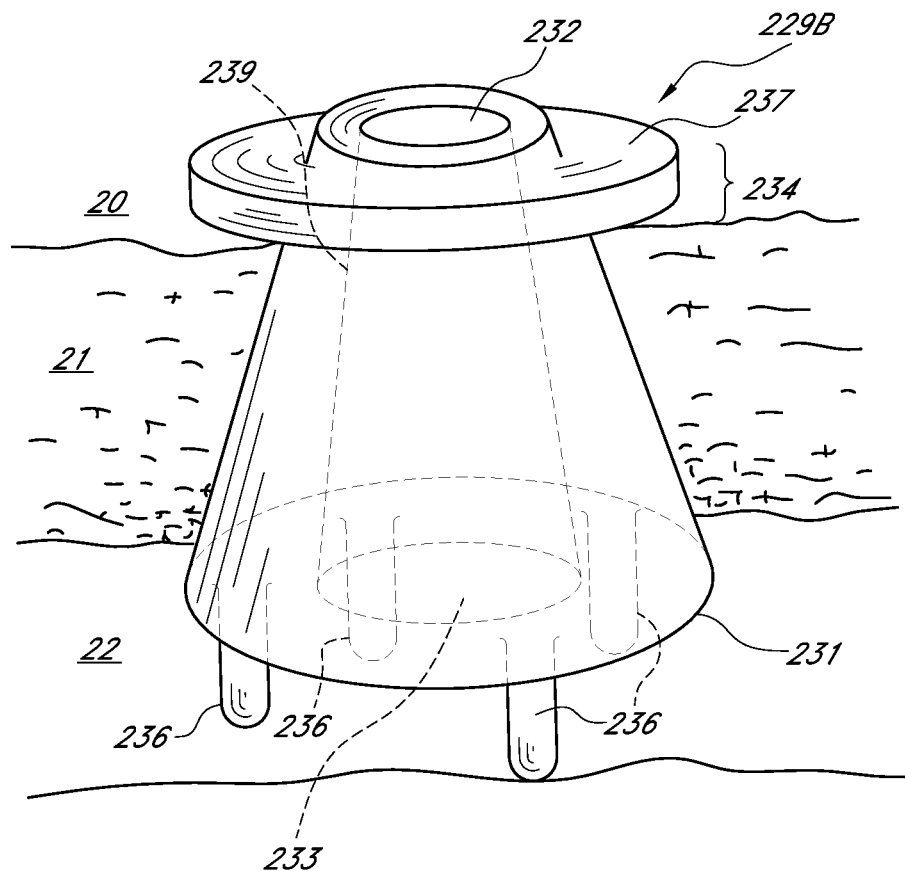


FIG. 49B

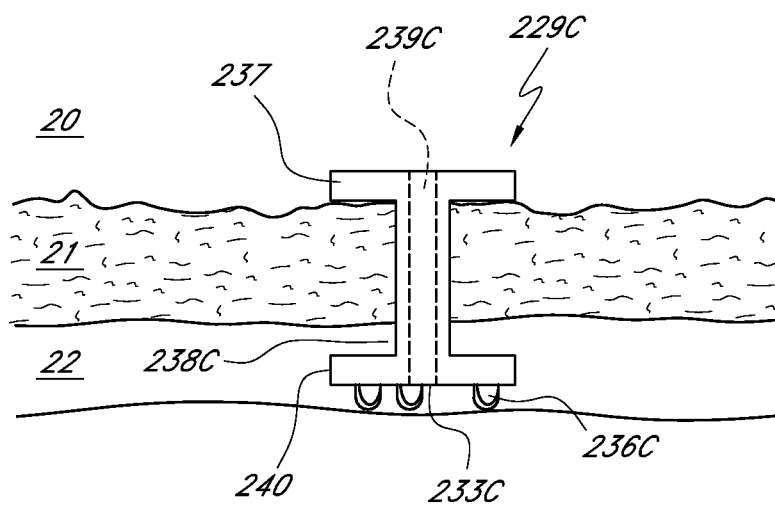


FIG. 49C

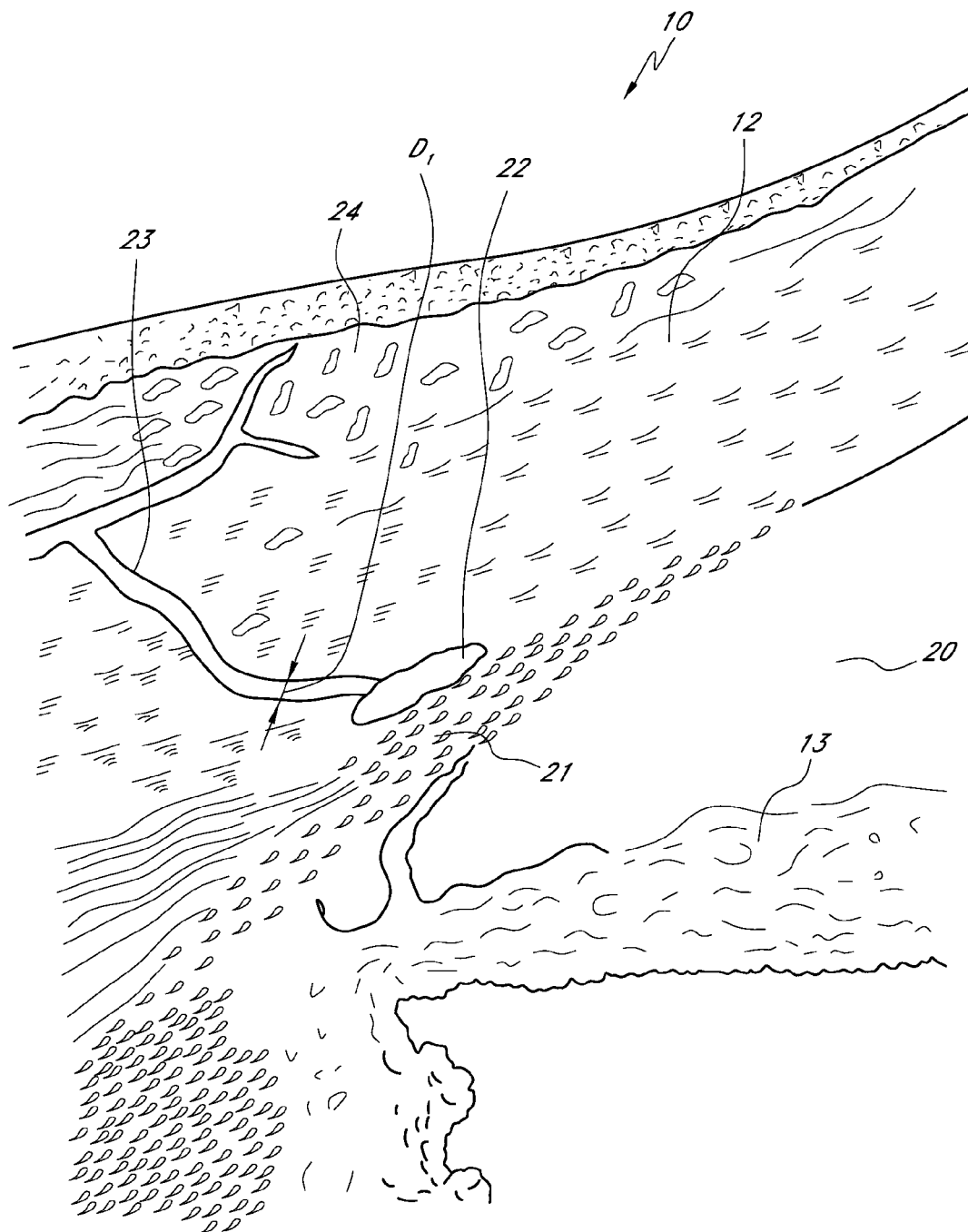


FIG. 50A

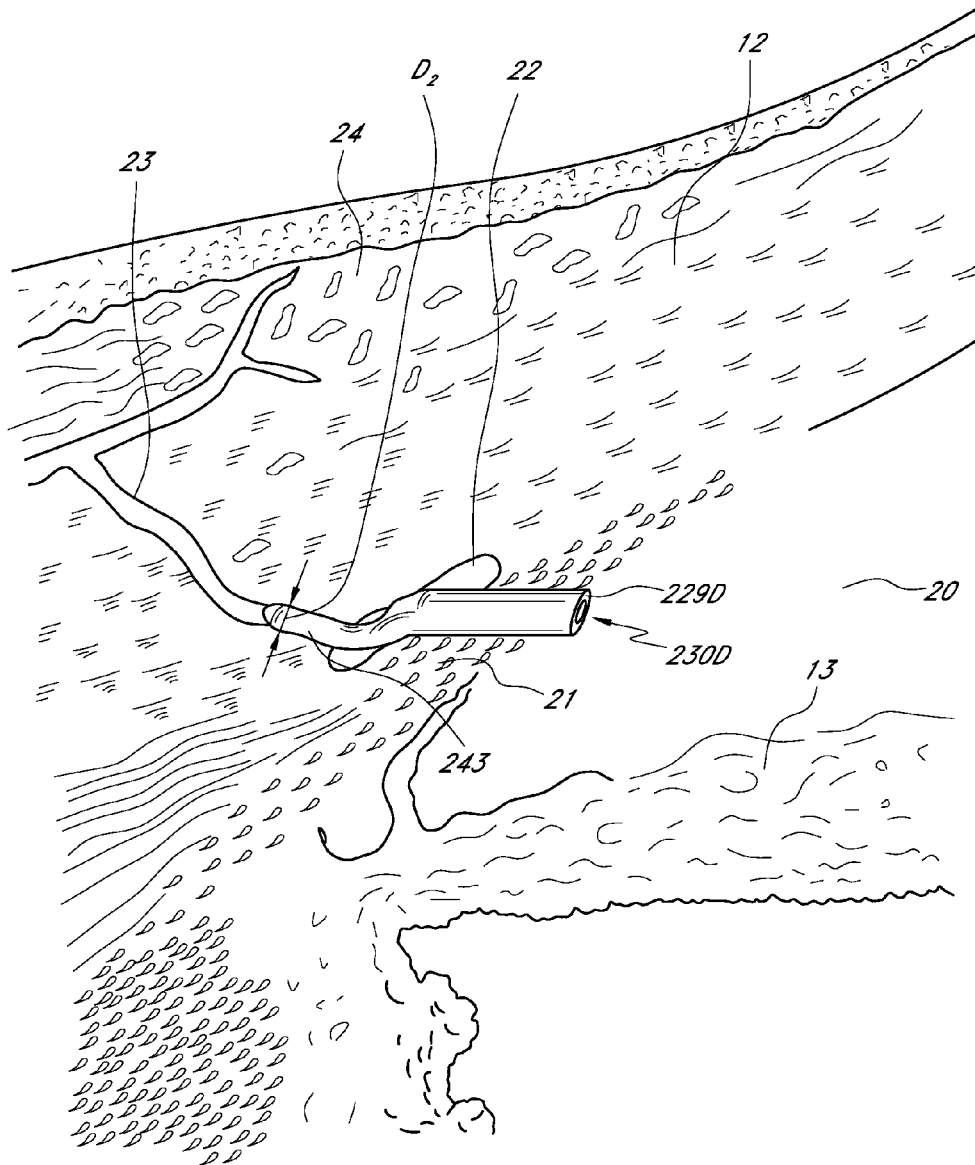


FIG. 50B



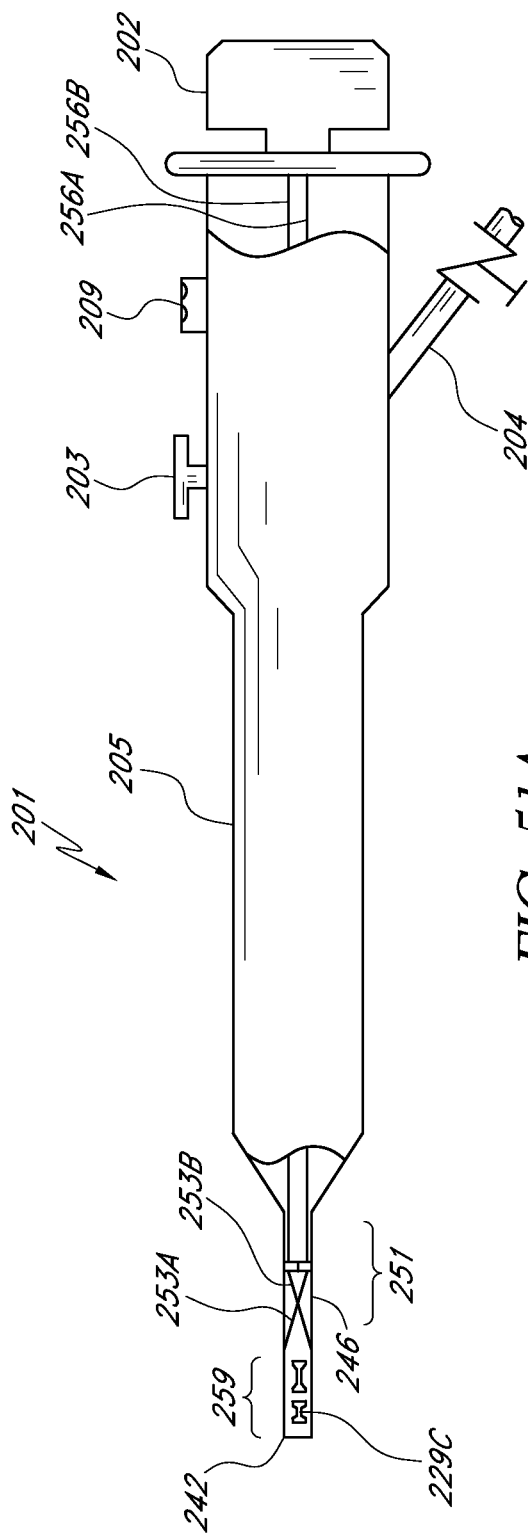


FIG. 51A

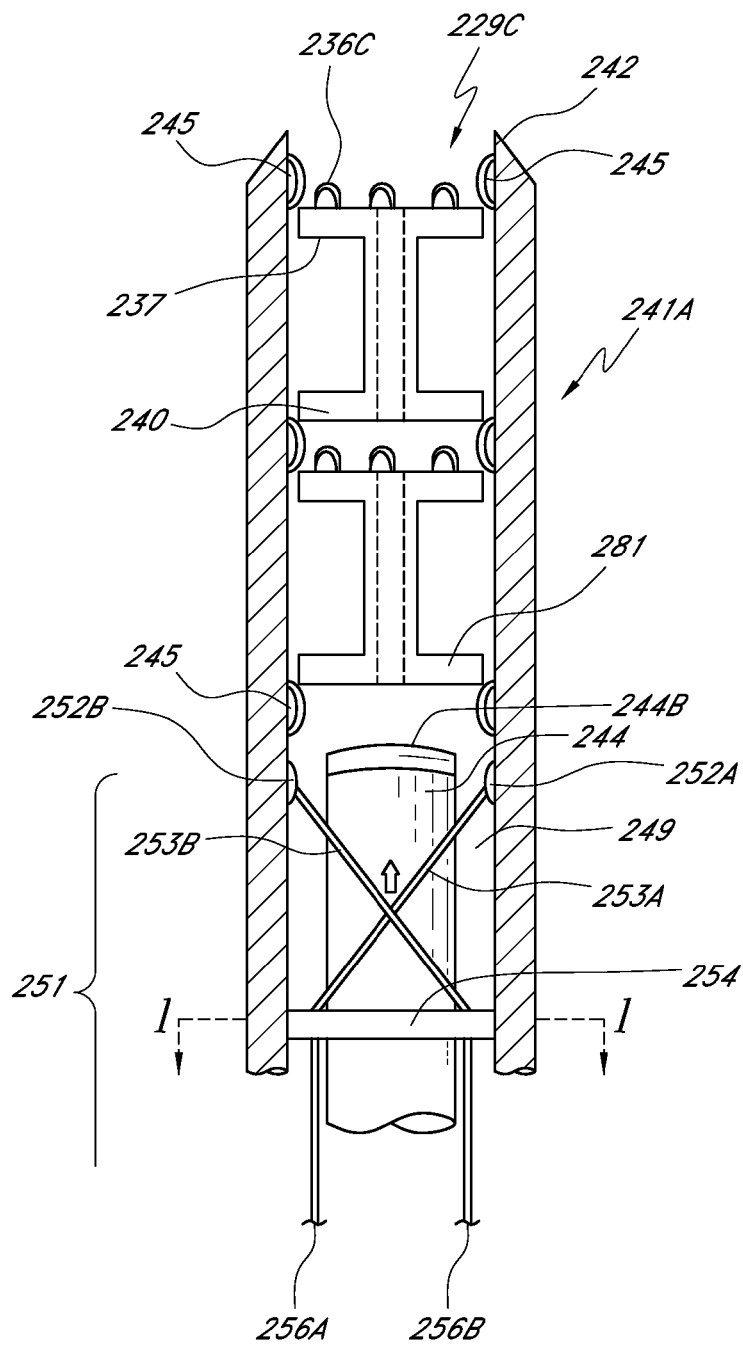


FIG. 51B

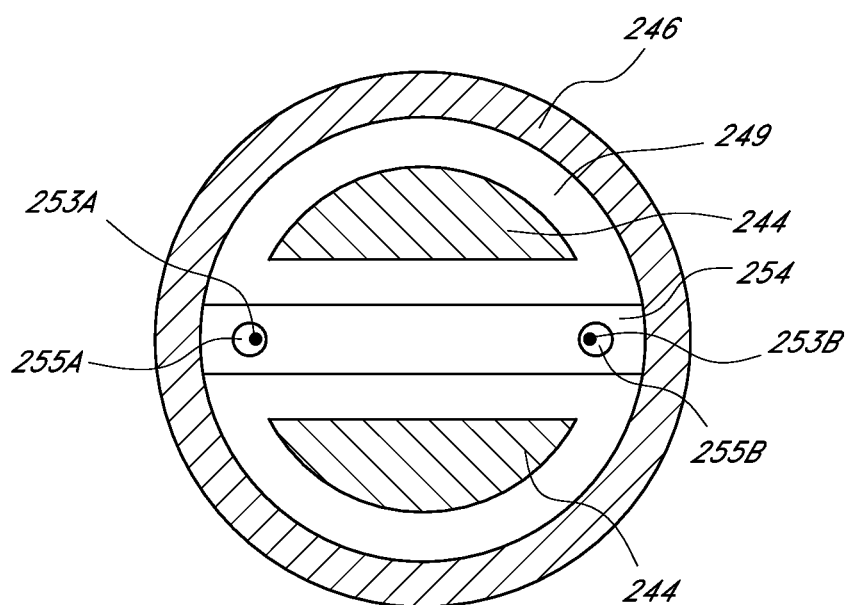
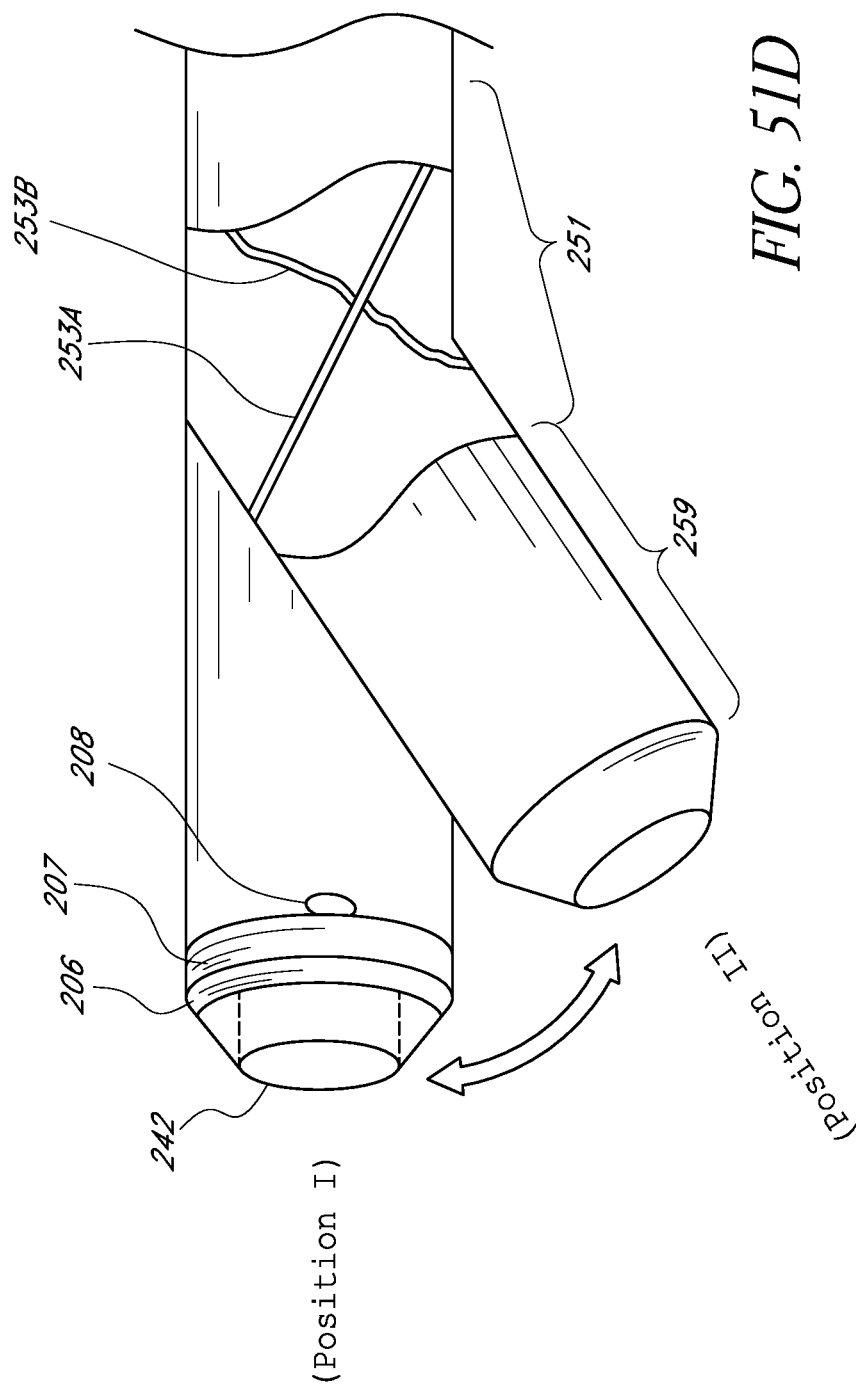


FIG. 51C



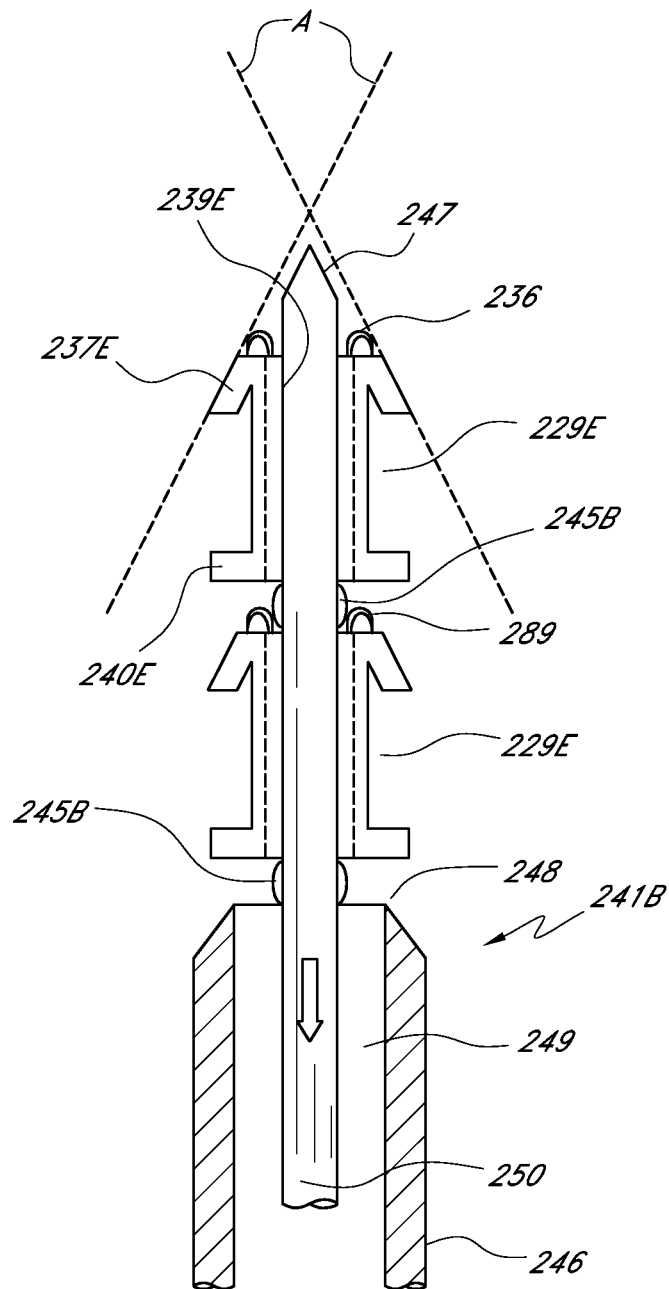


FIG. 52A

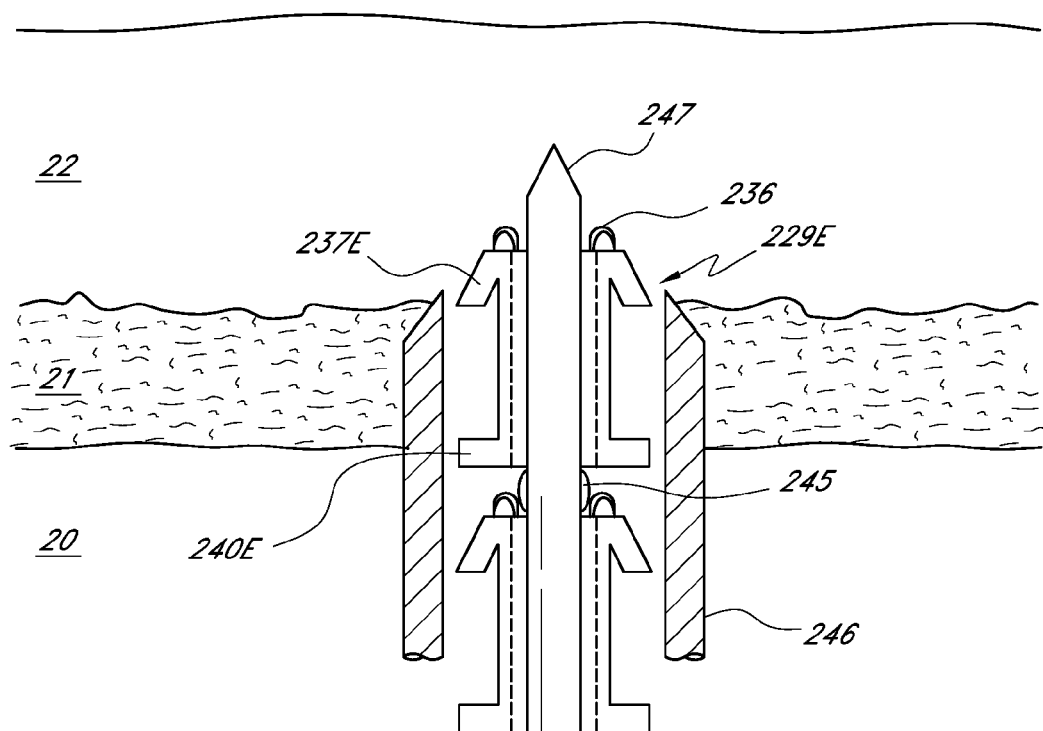


FIG. 52B

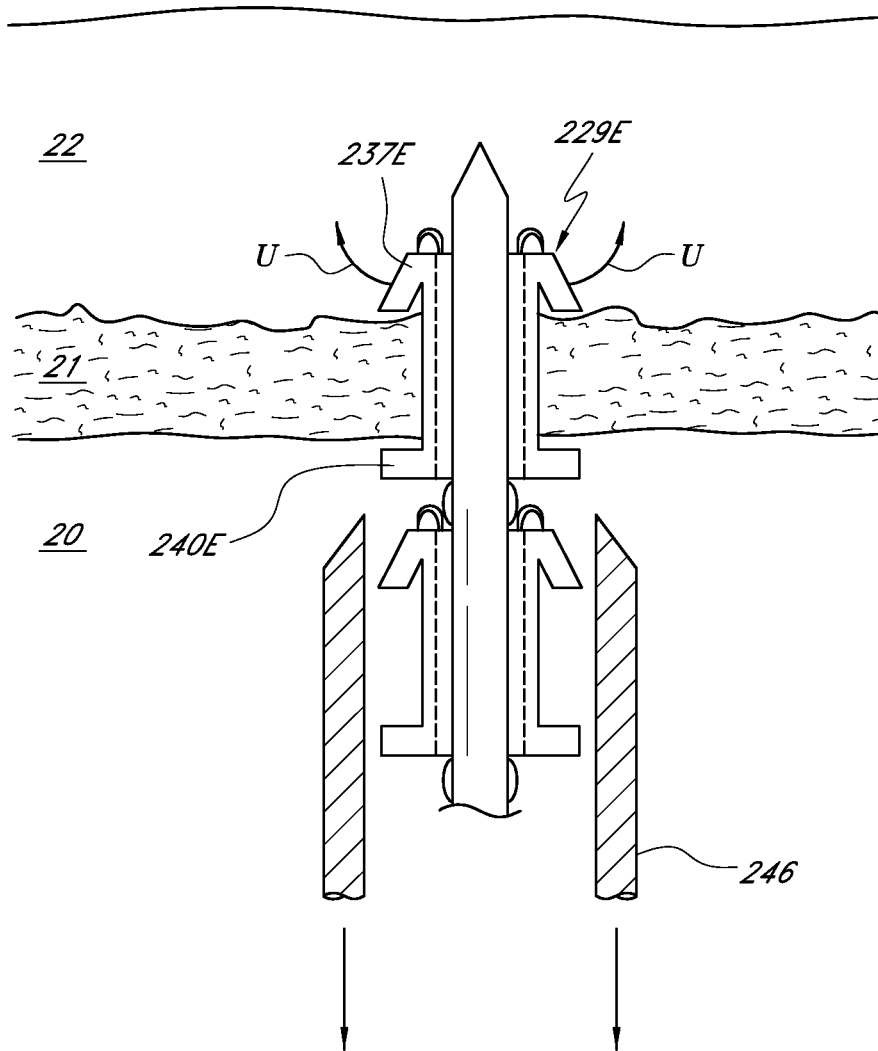


FIG. 52C

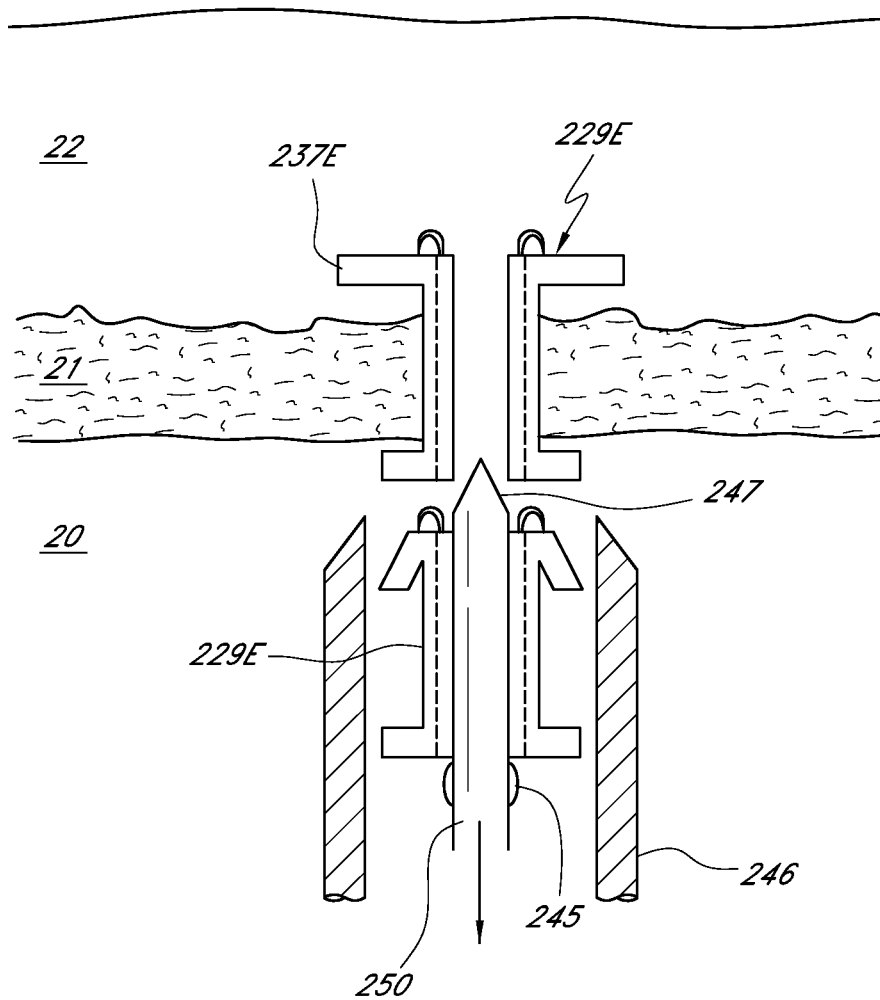
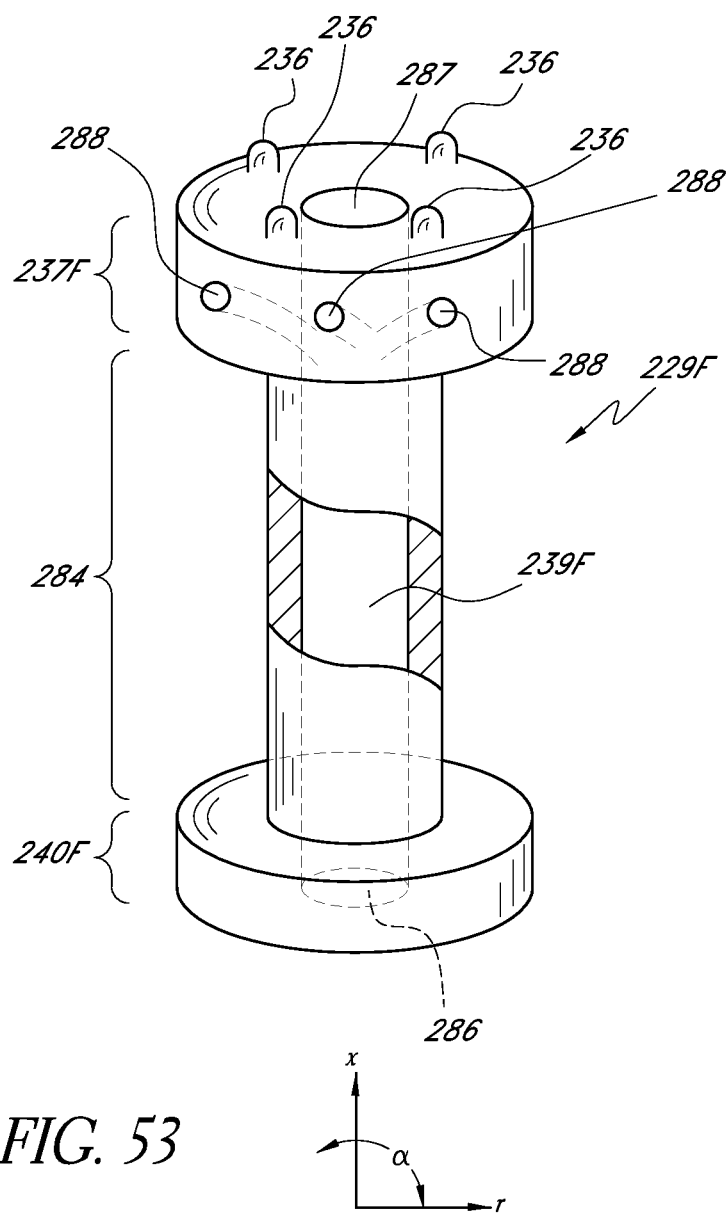


FIG. 52D





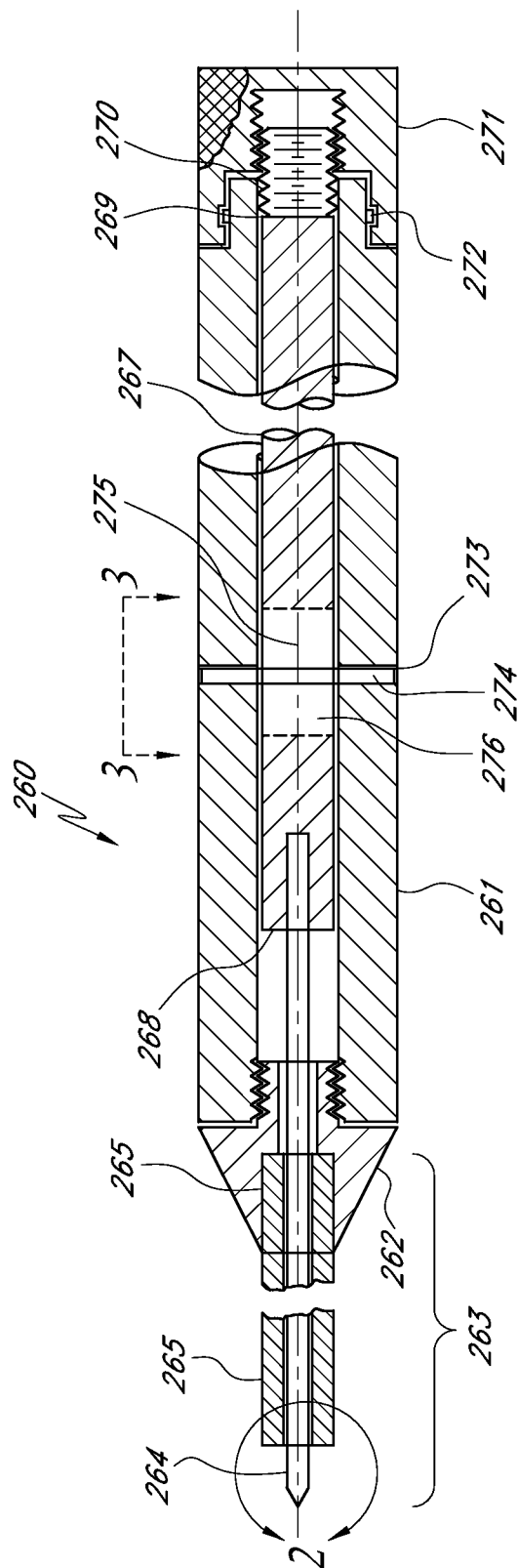


FIG. 54A

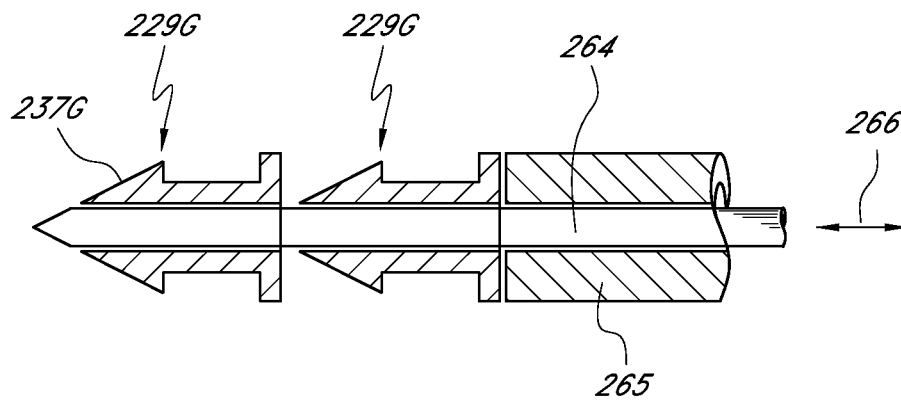


FIG. 54B

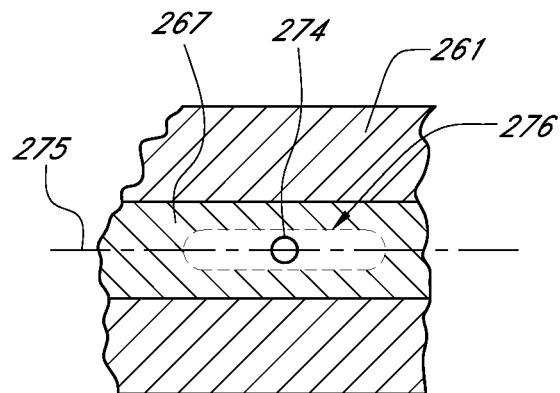


FIG. 54C

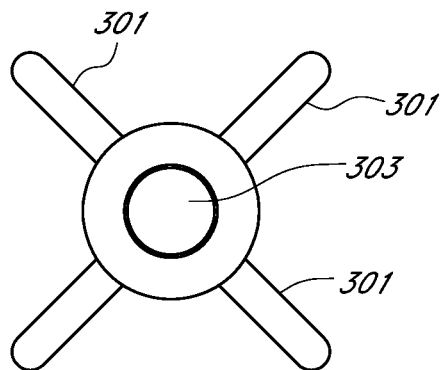


FIG. 55A

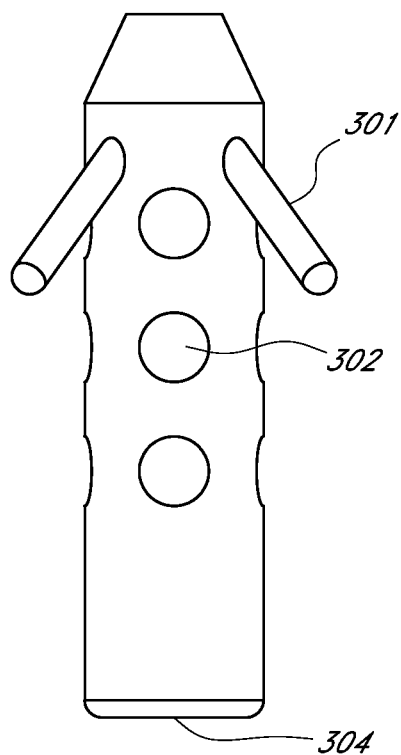


FIG. 55B

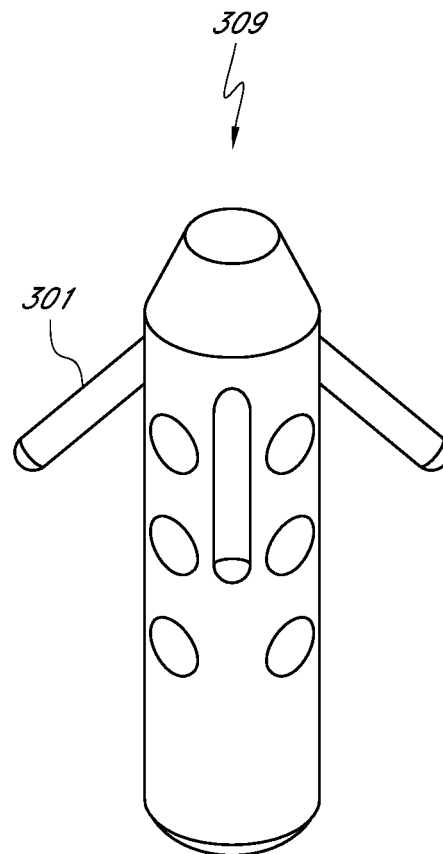


FIG. 55C

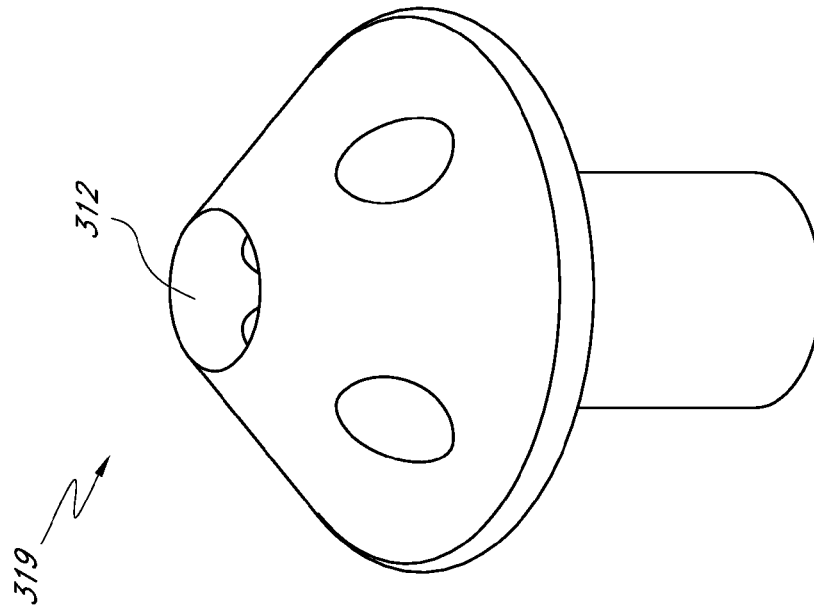


FIG. 56B

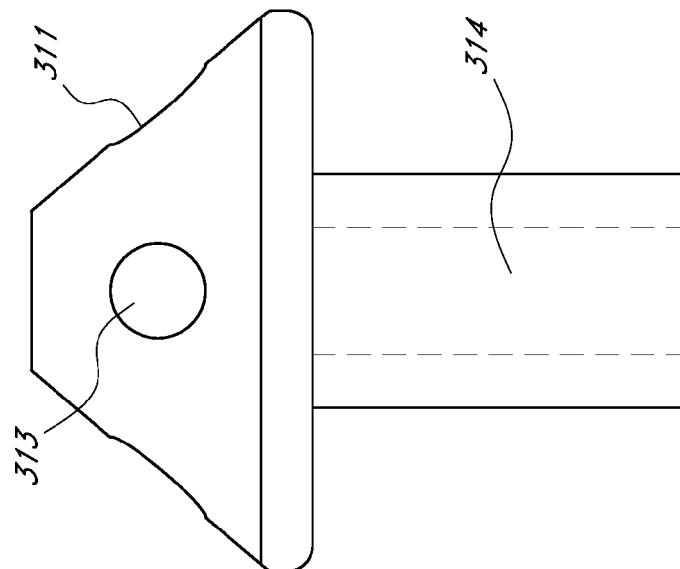


FIG. 56A

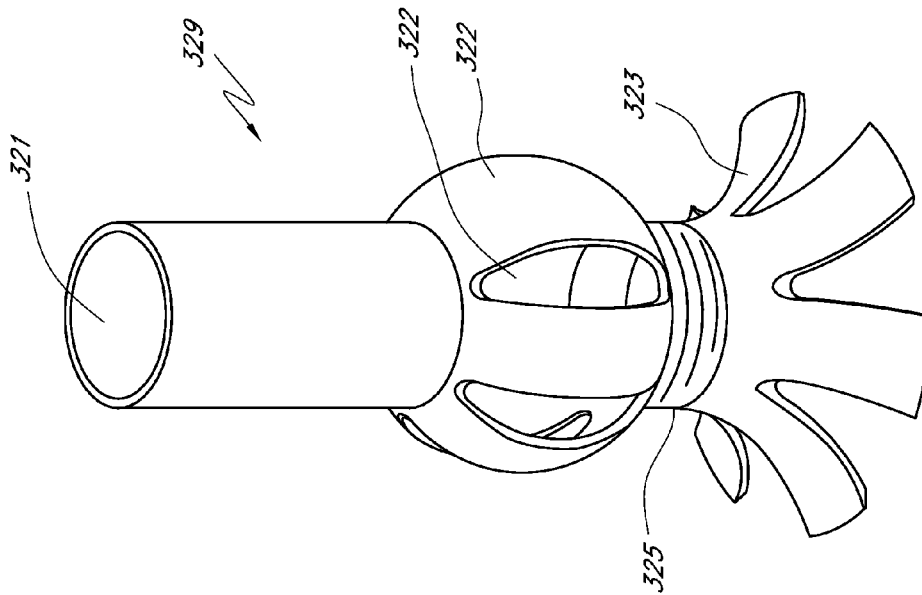


FIG. 57B

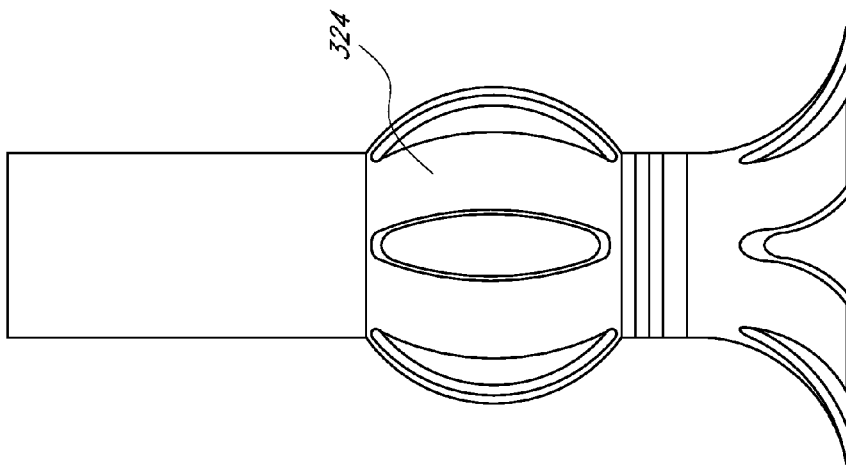


FIG. 57A

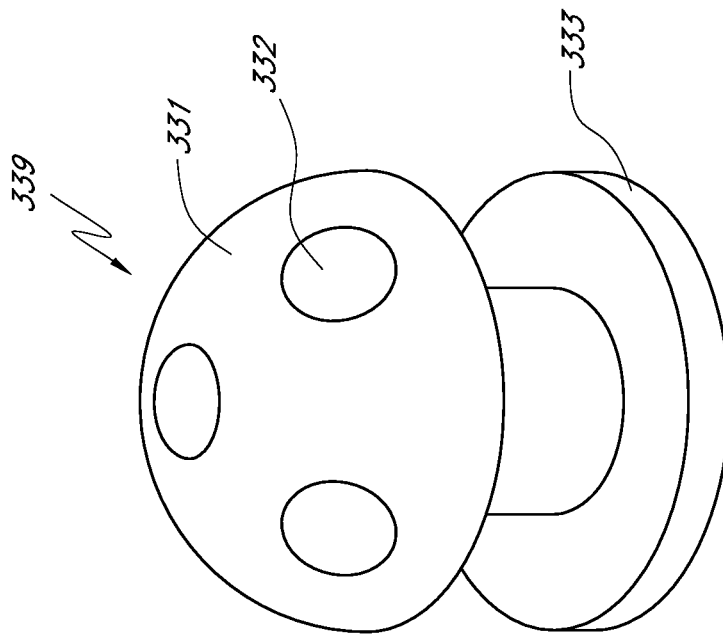


FIG. 58A

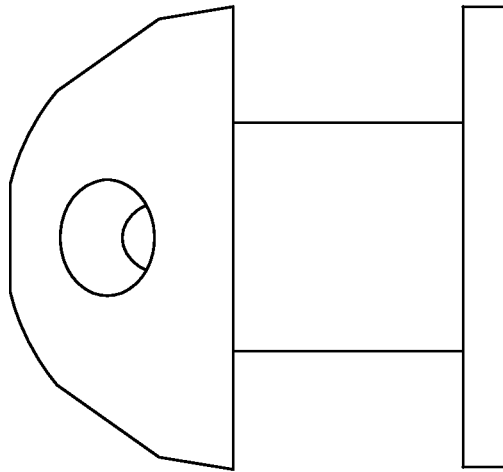


FIG. 58B

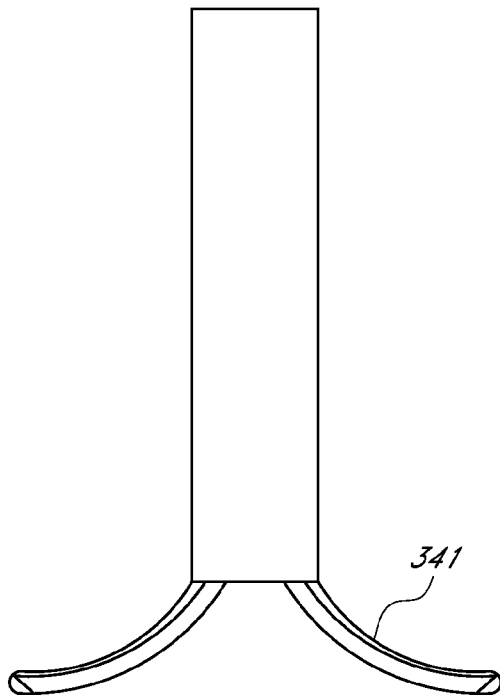


FIG. 59A

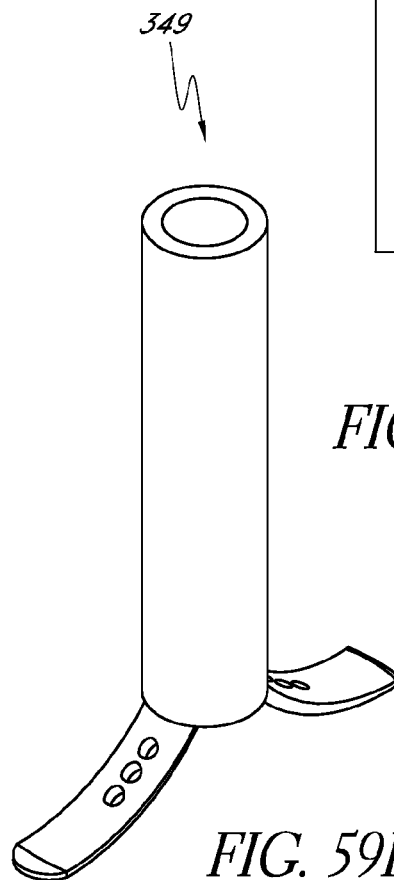


FIG. 59B



FIG. 59C



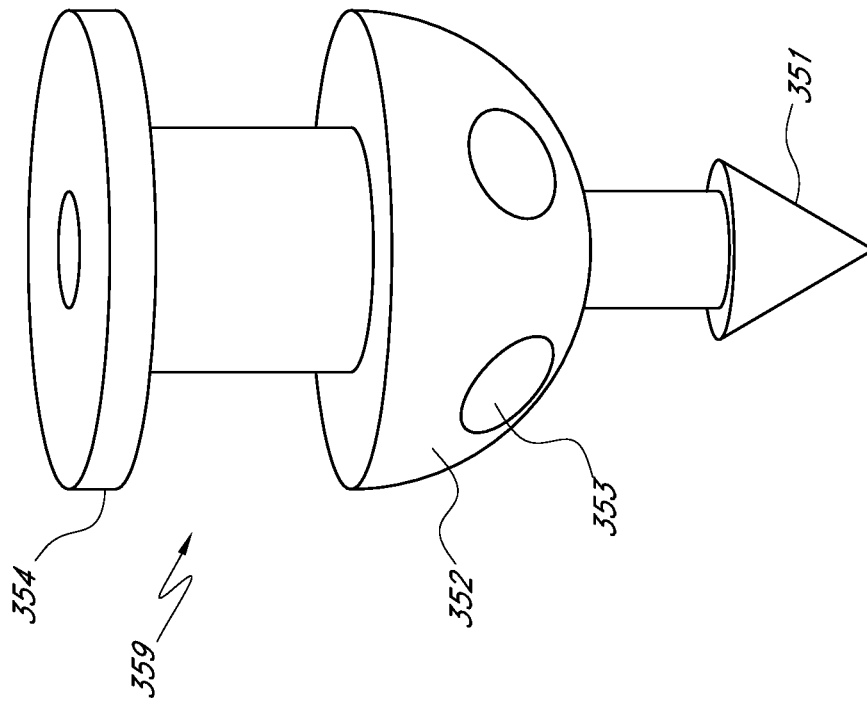


FIG. 60B

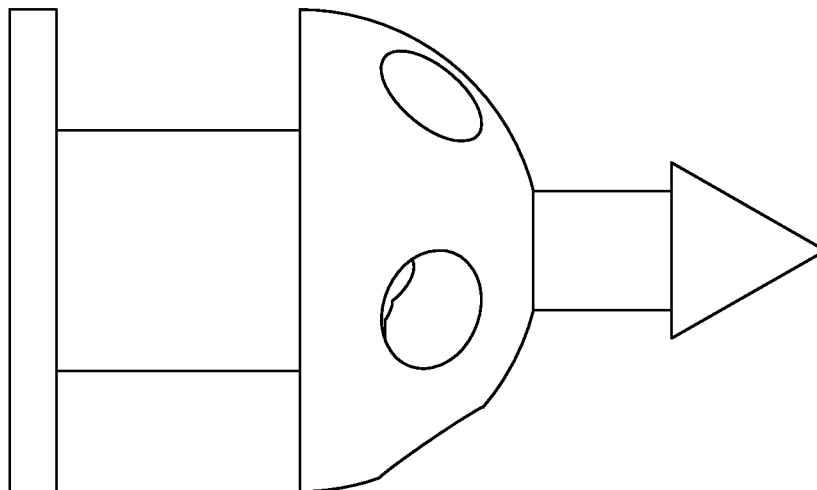
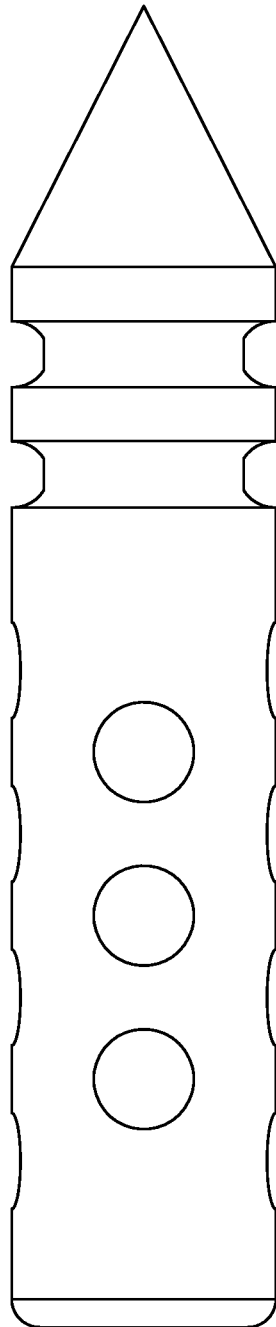
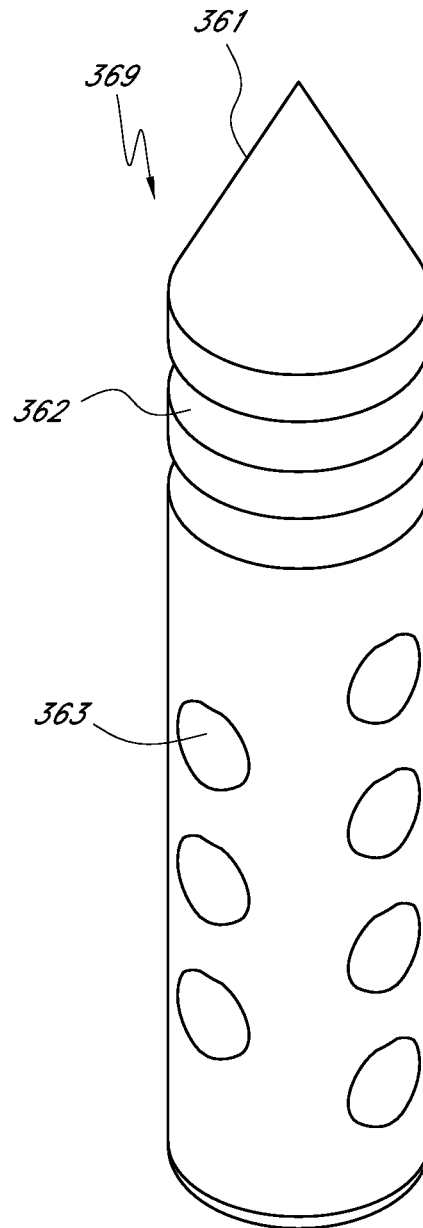


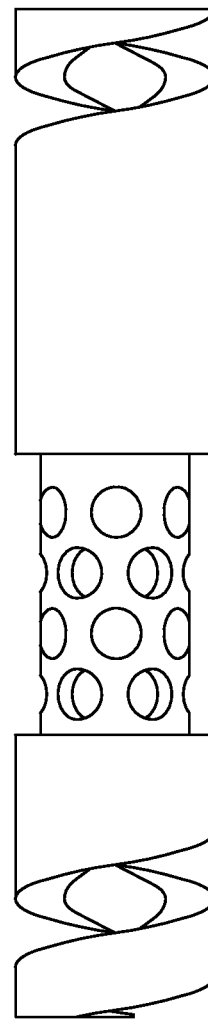
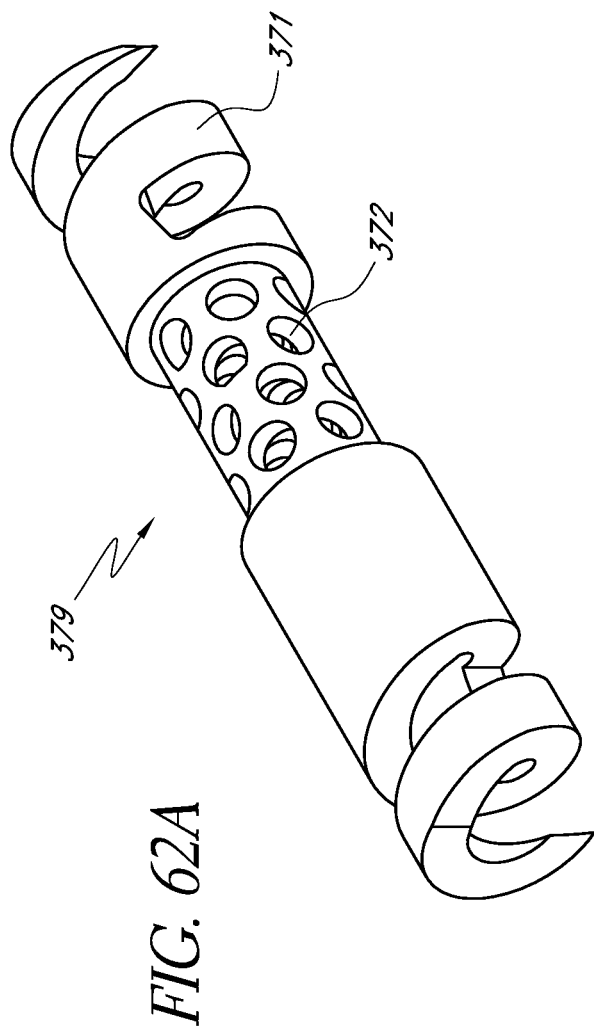
FIG. 60A



*FIG. 61A*



*FIG. 61B*



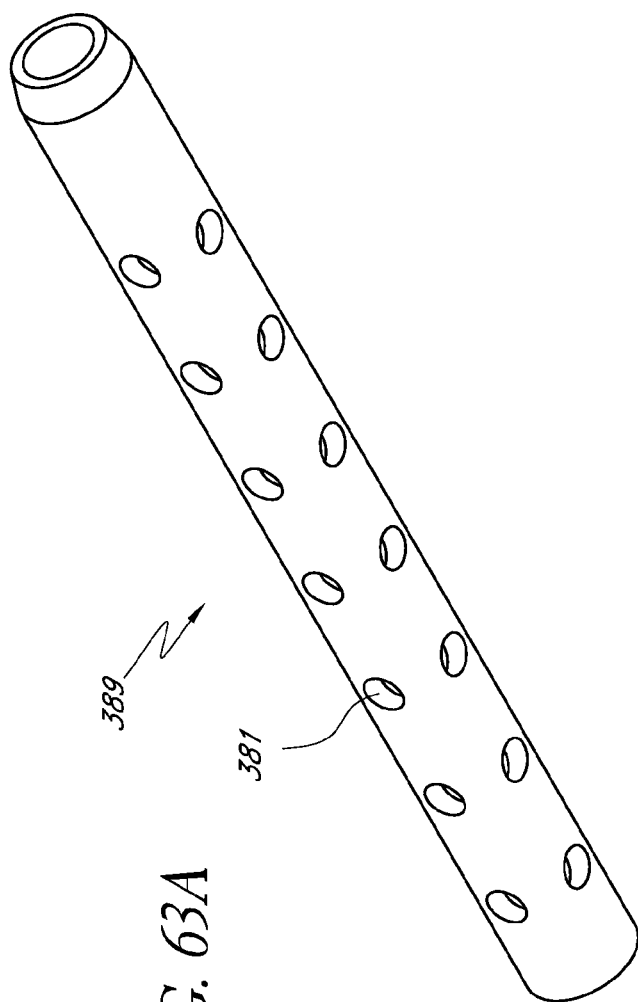


FIG. 63A



FIG. 63B

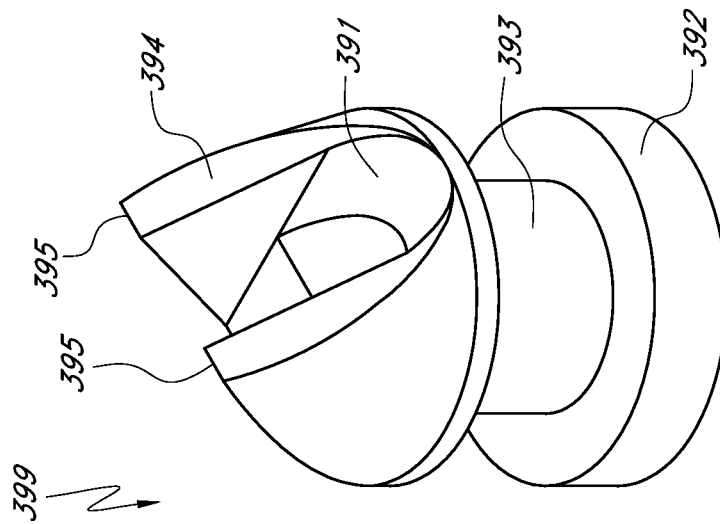


FIG. 64A

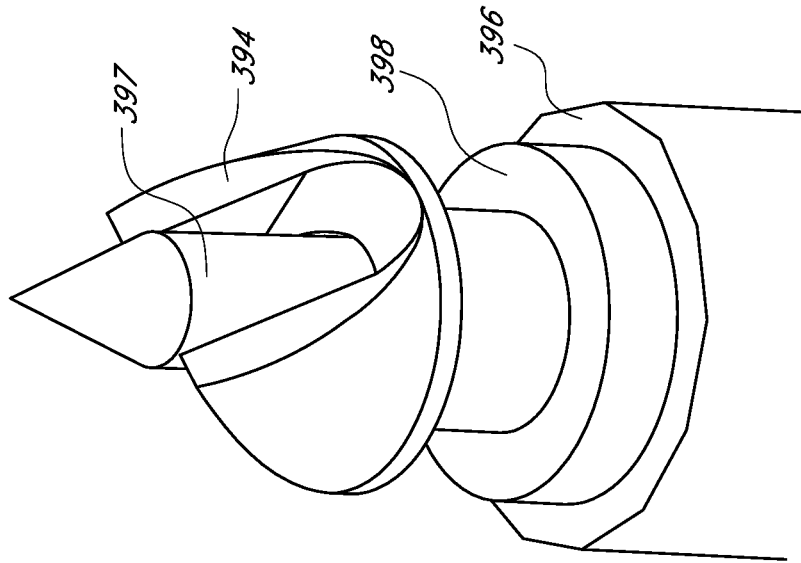


FIG. 64B

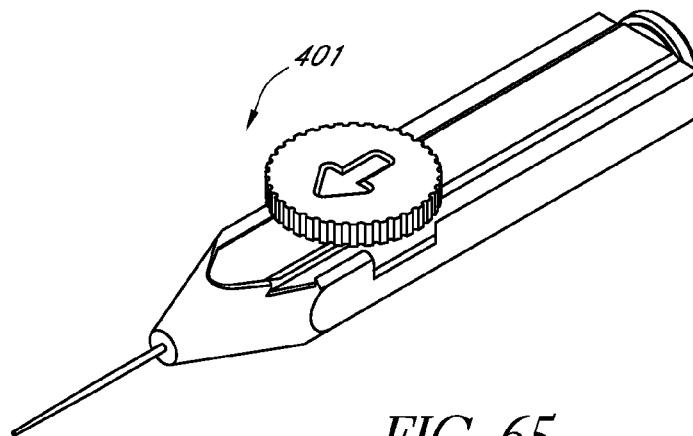


FIG. 65

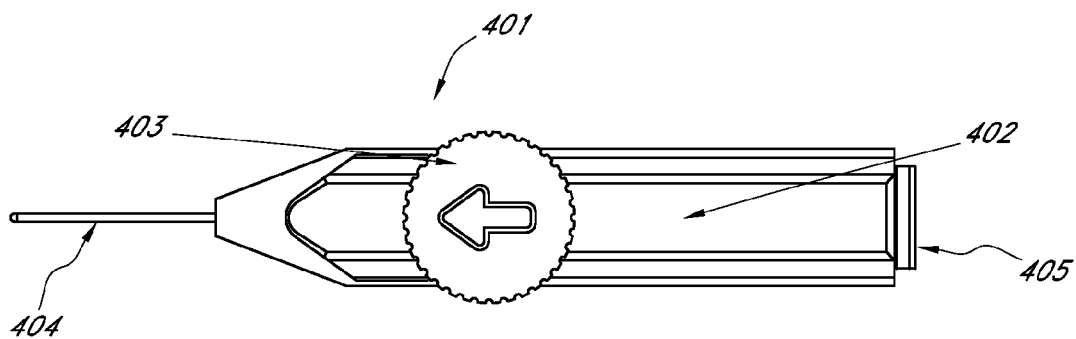


FIG. 66

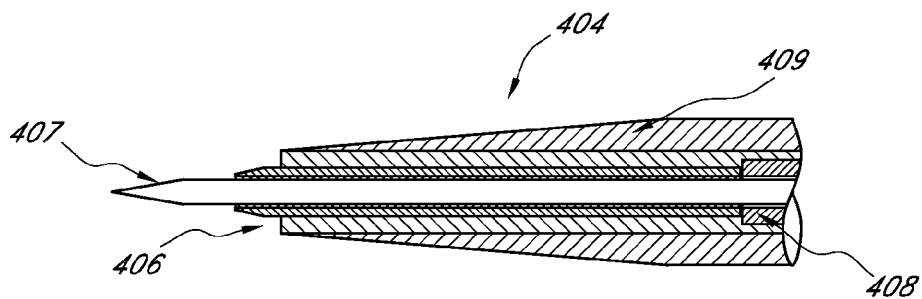


FIG. 67

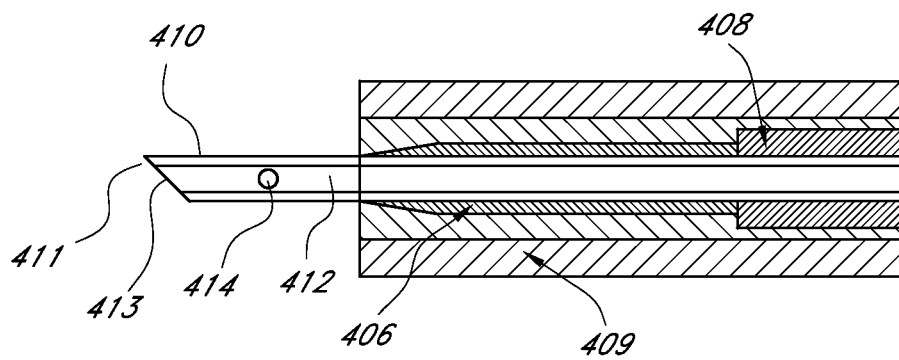


FIG. 68A

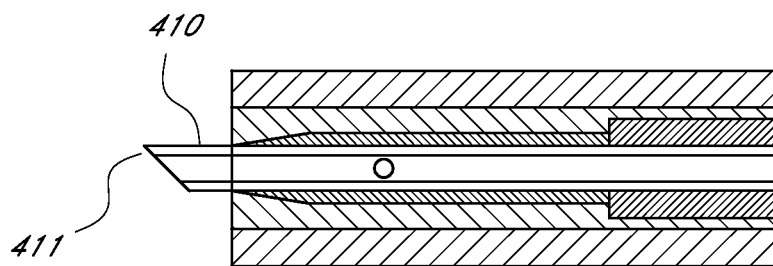


FIG. 68B

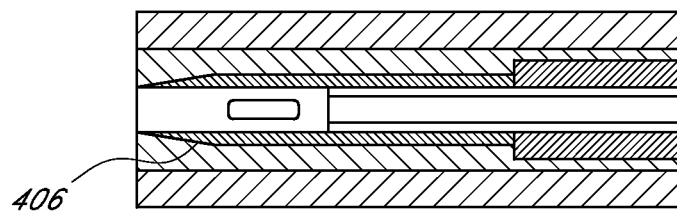


FIG. 68C

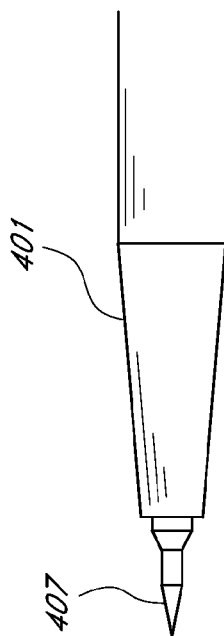


FIG. 69A

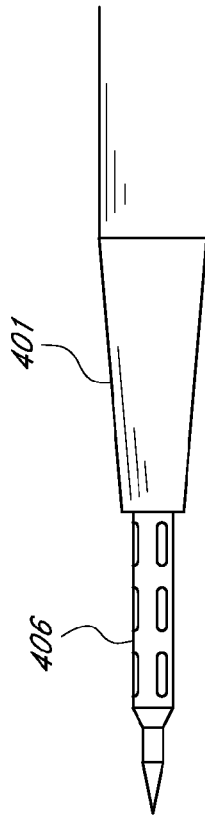


FIG. 69B

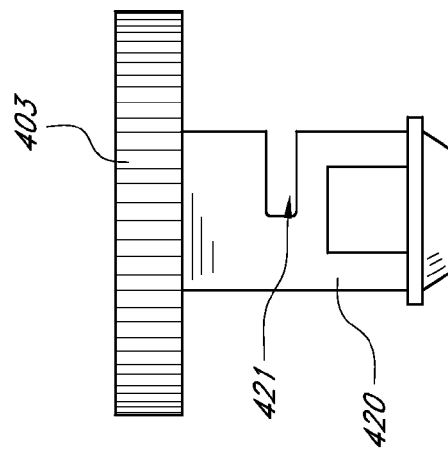


FIG. 70A

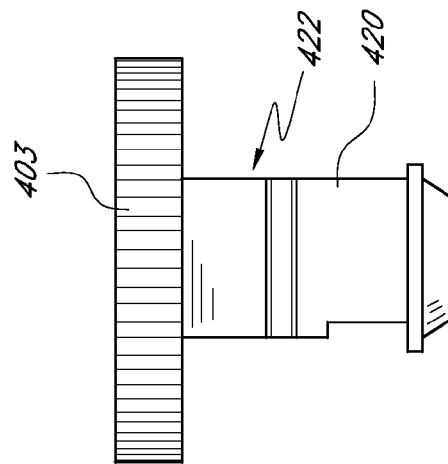


FIG. 70B



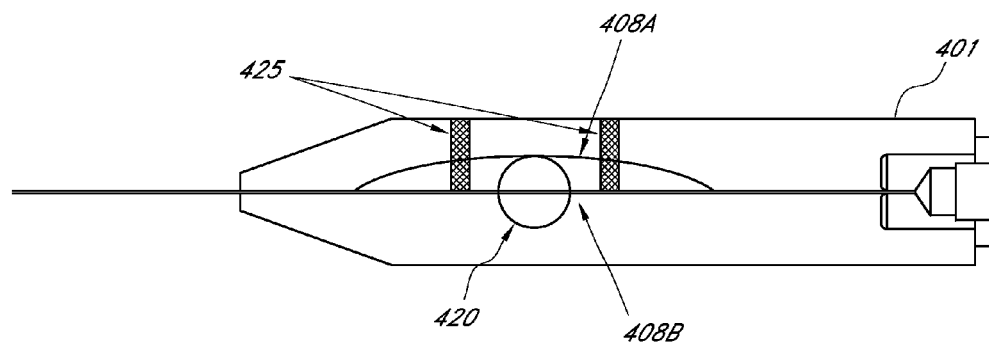


FIG. 71

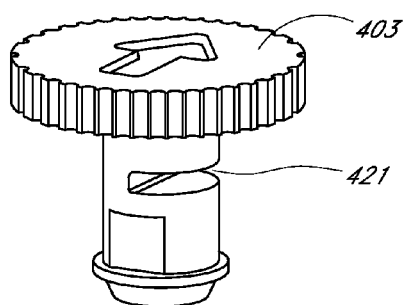


FIG. 72

# OCULAR SYSTEM WITH ANCHORING IMPLANT AND THERAPEUTIC AGENT

## CROSS REFERENCE TO RELATED APPLICATIONS

The present application is a continuation of U.S. patent application Ser. No. 12/246,448, filed Oct. 6, 2008 (the "Ser. No. 12/246,448 application"), now U.S. Pat. No. 8,118,768 B2, which is a divisional of U.S. patent application Ser. No. 11/083,713, filed Mar. 18, 2005 (the "Ser. No. 11/083,713 application"), now U.S. Pat. No. 7,431,710 B2, issued Oct. 7, 2008, which is a continuation-in-part of U.S. patent application Ser. No. 10/634,213, filed Aug. 5, 2003, now U.S. Pat. No. 7,867,186 B2, issued Jan. 11, 2011, which is a continuation-in-part of U.S. patent application Ser. No. 10/118,578, filed Apr. 8, 2002, now U.S. Pat. No. 7,135,009 B2, issued Nov. 14, 2006.

The Ser. No. 11/083,713 application is also a continuation-in-part of U.S. patent application Ser. No. 10/667,580, filed Sep. 22, 2003, now U.S. Pat. No. 7,488,303 B1, issued Feb. 10, 2009.

The Ser. No. 12/246,448 application is also a continuation-in-part of U.S. patent application Ser. No. 11/598,542, filed Nov. 13, 2006, now U.S. Pat. No. 7,563,241 B2, issued Jul. 21, 2009, which is a continuation of U.S. patent application Ser. No. 10/118,578, filed Apr. 8, 2002, now U.S. Pat. No. 7,135,009 B2, issued Nov. 14, 2006, which claims the priority benefit of U.S. Provisional Application No. 60/281,973, filed Apr. 7, 2001.

The present application claims priority to all of the aforementioned applications, and the entireties of each of these priority documents are hereby incorporated by reference.

## BACKGROUND OF THE INVENTIONS

### 1. Field of the Inventions

The present application relates generally to medical devices and methods for reducing the intraocular pressure in an animal eye and, more particularly, to shunt-type stenting devices for permitting and/or enhancing aqueous outflow from the eye's anterior chamber toward existing outflow pathways and associated methods thereof for the treatment of glaucoma in general.

### 2. Description of the Related Art

The human eye is a specialized sensory organ capable of light reception and able to receive visual images. The trabecular meshwork serves as a drainage channel and is located in the anterior chamber angle formed between the iris and the cornea. The trabecular meshwork maintains a balanced pressure in the anterior chamber of the eye by allowing aqueous humor to flow from the anterior chamber.

About two percent of people in the United States have glaucoma. Glaucoma is a group of eye diseases encompassing a broad spectrum of clinical presentations, etiologies, and treatment modalities. Glaucoma causes pathological changes in the optic nerve, visible on the optic disk, and it causes corresponding visual field loss, resulting in blindness if untreated. Lowering intraocular pressure is the major treatment goal in all glaucomas.

In glaucomas associated with an elevation in eye pressure (intraocular hypertension), the source of resistance to outflow of aqueous humor is mainly in the trabecular meshwork. The tissue of the trabecular meshwork allows the aqueous humor, or aqueous, to enter Schlemm's canal, which then empties into aqueous collector channels in the posterior wall of Schlemm's canal and then into aqueous veins, which form the

episcleral venous system. Aqueous humor is a transparent liquid that fills the region between the cornea, at the front of the eye, and the lens. The aqueous humor is continuously secreted by the ciliary body around the lens, so there is an essentially constant flow of aqueous humor from the ciliary body to the eye's anterior chamber. The anterior chamber pressure is determined by a balance between the production of aqueous and its exit through the trabecular meshwork (major route) or uveal scleral outflow (minor route). The trabecular meshwork is located between the outer rim of the iris and the back of the cornea, in the anterior chamber angle. The portion of the trabecular meshwork adjacent to Schlemm's canal (the juxtacanalicular meshwork) causes most of the resistance to aqueous outflow.

Glaucoma is grossly classified into two categories: closed-angle glaucoma, also known as "angle closure" glaucoma, and open-angle glaucoma. Closed-angle glaucoma is caused by closure of the anterior chamber angle by contact between the iris and the inner surface of the trabecular meshwork. Closure of this anatomical angle prevents normal drainage of aqueous humor from the anterior chamber of the eye.

Open-angle glaucoma is any glaucoma in which the angle of the anterior chamber remains open, but the exit of aqueous through the trabecular meshwork is diminished. The exact cause for diminished filtration is unknown for most cases of open-angle glaucoma. Primary open-angle glaucoma is the most common of the glaucomas, and it is often asymptomatic in the early to moderately advanced stage. Patients may suffer substantial, irreversible vision loss prior to diagnosis and treatment. However, there are secondary open-angle glaucomas which may include edema or swelling of the trabecular spaces (e.g., from corticosteroid use), abnormal pigment dispersion, or diseases such as hyperthyroidism that produce vascular congestion.

Current therapies for glaucoma are directed at decreasing intraocular pressure. Medical therapy includes topical ophthalmic drops or oral medications that reduce the production or increase the outflow of aqueous. However, these drug therapies for glaucoma are sometimes associated with significant side effects, such as headache, blurred vision, allergic reactions, death from cardiopulmonary complications, and potential interactions with other drugs. When drug therapy fails, surgical therapy is used. Surgical therapy for open-angle glaucoma consists of laser trabeculoplasty, trabeculectomy, and implantation of aqueous shunts after failure of trabeculectomy or if trabeculectomy is unlikely to succeed. Trabeculectomy is a major surgery that is widely used and is augmented with topically applied anticancer drugs, such as 5-fluorouracil or mitomycin-C to decrease scarring and increase the likelihood of surgical success.

Approximately 100,000 trabeculectomies are performed on Medicare-age patients per year in the United States. This number would likely increase if the morbidity associated with trabeculectomy could be decreased. The current morbidity associated with trabeculectomy consists of failure (10-15%); infection (a life long risk of 2-5%); choroidal hemorrhage, a severe internal hemorrhage from low intraocular pressure, resulting in visual loss (1%); cataract formation; and hypotony maculopathy (potentially reversible visual loss from low intraocular pressure).

For these reasons, surgeons have tried for decades to develop a workable surgery for the trabecular meshwork.

The surgical techniques that have been tried and practiced are goniotomy/trabeculotomy and other mechanical disruptions of the trabecular meshwork, such as trabeculopuncture,

goniophotocoagulation, laser trabecular ablation, and goniosynovectomy. These are all major operations and are briefly described below.

Goniotomy/Trabeculotomy: Goniotomy and trabeculotomy are simple and directed techniques of microsurgical dissection with mechanical disruption of the trabecular meshwork. These initially had early favorable responses in the treatment of open-angle glaucoma. However, long-term review of surgical results showed only limited success in adults. In retrospect, these procedures probably failed due to cellular repair and fibrosis mechanisms and a process of "filling in." Filling in is a detrimental effect of collapsing and closing in of the opening created in the trabecular meshwork. Once the openings close, the pressure builds back up and the surgery fails.

Trabeculopuncture: Q-switched Neodymium (Nd) YAG lasers also have been investigated as an optically invasive technique for creating full-thickness holes in trabecular meshwork. However, the relatively small hole created by this trabeculopuncture technique exhibits a filling-in effect and fails.

Goniotomy/Laser Trabecular Ablation: Goniotomy is disclosed by Berlin in U.S. Pat. No. 4,846,172 and involves the use of an excimer laser to treat glaucoma by ablating the trabecular meshwork. This was demonstrated not to succeed by clinical trial. Hill et al. disclosed the use of an Erbium:YAG laser to create full-thickness holes through trabecular meshwork (Hill et al., *Lasers in Surgery and Medicine* 11:341-346, 1991). This technique was investigated in a primate model and a limited human clinical trial at the University of California, Irvine. Although morbidity was zero in both trials, success rates did not warrant further human trials. Failure was again from filling in of surgically created defects in the trabecular meshwork by repair mechanisms. Neither of these is a viable surgical technique for the treatment of glaucoma.

Goniosynovectomy: This is an ab interno (from the inside), mechanically disruptive technique that uses an instrument similar to a cyclodialysis spatula with a microcurette at the tip. Initial results were similar to goniotomy: it failed due to repair mechanisms and a process of filling in.

Although trabeculectomy is the most commonly performed filtering surgery, viscocanalostomy (VC) and non-penetrating trabeculectomy (NPT) are two new variations of filtering surgery. These are ab externo (from the outside), major ocular procedures in which Schlemm's canal is surgically exposed by making a large and very deep scleral flap. In the VC procedure, Schlemm's canal is cannulated and viscoelastic substance injected (which dilates Schlemm's canal and the aqueous collector channels). In the NPT procedure, the inner wall of Schlemm's canal is stripped off after surgically exposing the canal.

Trabeculectomy, VC, and NPT involve the formation of an opening or hole under the conjunctiva and scleral flap into the anterior chamber, such that aqueous humor is drained onto the surface of the eye or into the tissues located within the lateral wall of the eye. These surgical operations are major procedures with significant ocular morbidity. Where trabeculectomy, VC, and NPT were thought to have a low chance for success in particular cases, a number of implantable drainage devices have been used to ensure that the desired filtration and outflow of aqueous humor through the surgical opening will continue. The risk of placing a glaucoma drainage device also includes hemorrhage, infection, and diplopia (double vision).

Examples of implantable shunts and surgical methods for maintaining an opening for the release of aqueous humor from the anterior chamber of the eye to the sclera or space

beneath the conjunctiva have been disclosed in, for example, U.S. Pat. No. 6,059,772 to Hsia et al., U.S. Pat. No. 6,050,970 to Baerveldt, U.S. Pat. No. 6,468,283 to Richter et al., and U.S. Pat. No. 6,471,666 to Odlich.

All of the above surgeries and variations thereof have numerous disadvantages and moderate success rates. They involve substantial trauma to the eye and require great surgical skill in creating a hole through the full thickness of the sclera into the subconjunctival space. The procedures are generally performed in an operating room and have a prolonged recovery time for vision.

The complications of existing filtration surgery have prompted ophthalmic surgeons to find other approaches to lowering intraocular pressure or treating tissue of trabecular meshwork.

The trabecular meshwork and juxtacanalicular tissue together provide the majority of resistance to the outflow of aqueous and, as such, are logical targets for tissue stimulation/rejuvenating or shunting in the treatment of open-angle glaucoma. In addition, minimal amounts of tissue are displaced and functions of the existing physiologic outflow pathways are restored.

As reported in *Arch. Ophthalmol.* (2000) 118:412, glaucoma remains a leading cause of blindness, and filtration surgery remains an effective, important option in controlling the disease. However, modifying existing filtering surgery techniques in any profound way to increase their effectiveness appears to have reached a dead end. The article further states that the time has come to search for new surgical approaches that may provide better and safer care for patients with glaucoma.

#### SUMMARY OF THE INVENTIONS

There is a great clinical need for an improved method of treating glaucoma that is faster, safer, and less expensive than currently available drug or surgical modalities. The methods disclosed herein include ab interno and ab externo procedures that involve non-flap operations. The methods herein may further comprise using an innovative stenting device.

The trabecular meshwork and juxtacanalicular tissue together provide the majority of resistance to the outflow of aqueous and, as such, are logical targets for the treatment of glaucoma. Various embodiments of glaucoma devices and methods are disclosed herein for treating glaucoma by an ab interno procedure or an ab externo procedure, with respect to trabecular meshwork. The "ab interno" procedure is herein intended to mean any procedure that creates an opening from the anterior chamber through trabecular meshwork outwardly toward Schlemm's canal or toward scleral/cornea wall. This ab interno procedure may be initiated through the scleral wall or cornea wall into the anterior chamber as a first step. The "ab externo" procedure is herein intended to mean any procedure that creates an opening on the scleral wall through trabecular meshwork inwardly toward the anterior chamber. In most "ab externo" procedures disclosed herein, an instrument is passed through or contacts Schlemm's canal before entering trabecular meshwork and approaching the anterior chamber. The trabecular meshwork can generally be said to be bordered on one side by the anterior chamber and on the other side by Schlemm's canal.

Glaucoma surgical morbidity would greatly decrease if one were to bypass the focal resistance to outflow of aqueous only at the point of resistance, and to utilize remaining, healthy aqueous outflow mechanisms. This is in part because episcleral aqueous humor exerts a backpressure that prevents intraocular pressure from falling too low, and one could

5

thereby avoid hypotony. Thus, such a surgery may virtually eliminate the risk of hypotony-related maculopathy and choroidal hemorrhage. Furthermore, visual recovery would be very rapid, and the risk of infection may be very small, reflecting a reduction in incidence from 2-5% to about 0.05%.

Copending U.S. application Ser. No. 09/549,350, filed Apr. 14, 2000, entitled APPARATUS AND METHOD FOR TREATING GLAUCOMA, now U.S. Pat. No. 6,638,239, and U.S. application Ser. No. 09/704,276, filed Nov. 1, 2000, entitled GLAUCOMA TREATMENT DEVICE, now U.S. Pat. No. 6,736,791, disclose devices and methods of placing a trabecular shunt ab interno, i.e., from inside the anterior chamber through the trabecular meshwork, into Schlemm's canal. The entire contents of each one of these copending patent applications are hereby incorporated by reference herein. This application encompasses both ab interno and ab externo glaucoma shunts or stents and methods thereof.

One technique performed in accordance with certain aspects herein can be referred to generally as "trabecular bypass surgery." Advantages of this type of surgery include lowering intraocular pressure in a manner which is simple, effective, disease site-specific, and can potentially be performed on an outpatient basis.

Generally, trabecular bypass surgery (TBS) creates an opening, a slit, or a hole through trabecular meshwork with minor microsurgery. TBS has the advantage of a much lower risk of choroidal hemorrhage and infection than prior techniques, and it uses existing physiologic outflow mechanisms. In some aspects, this surgery can potentially be performed under topical or local anesthesia on an outpatient basis with rapid visual recovery. To prevent "filling in" of the hole, a biocompatible elongated hollow device is placed within the hole and serves as a stent. U.S. Pat. No. 6,638,239 and the corresponding PCT application, PCT/US01/07398, filed Mar. 8, 2001, published as WO 01/78631A2, the entire contents of which are hereby incorporated by reference herein, disclose trabecular bypass surgery in details.

As described in U.S. Pat. Nos. 6,638,239 and 6,736,791, a trabecular shunt or stent for transporting aqueous humor is provided. The trabecular stent includes a hollow, elongate tubular element, having an inlet section and an outlet section. The outlet section may optionally include two segments or elements, adapted to be positioned and stabilized inside Schlemm's canal. In one embodiment, the device appears as a "T" shaped device. In another embodiment, the device appears as a "L" shaped device. In still another embodiment, the device appears as a "I" shaped embodiment.

In accordance with some embodiments disclosed herein, a delivery apparatus (or "applicator") is used for placing a trabecular stent through a trabecular meshwork of an eye. Certain embodiments of such a delivery apparatus are disclosed in U.S. application Ser. No. 10/101,548, filed Mar. 18, 2002, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT, and U.S. Provisional Application No. 60/276,609, filed Mar. 16, 2001, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT, the entire contents of each of which are hereby incorporated by reference herein.

The stent has an inlet section and an outlet section. In one embodiment, the delivery apparatus includes a handpiece, an elongate tip, a holder and an actuator. The handpiece has a distal end and a proximal end. The elongate tip is connected to the distal end of the handpiece. The elongate tip has a distal portion and is configured to be placed through a corneal incision and into an anterior chamber of the eye. The holder is attached to the distal portion of the elongate tip. The holder is

6

configured to hold and release the inlet section of the trabecular stent. The actuator is on the handpiece and actuates the holder to release the inlet section of the trabecular stent from the holder. When the trabecular stent is deployed from the delivery apparatus into the eye, the outlet section is positioned in substantially opposite directions inside Schlemm's canal. In one embodiment, a deployment mechanism within the delivery apparatus includes a push-pull type plunger.

Some embodiments disclosed herein relate to devices for reducing intraocular pressure by providing outflow of aqueous from an anterior chamber of an eye. The device generally comprises an elongated tubular member and cutting means. The tubular member is adapted for extending through a trabecular meshwork of the eye. The tubular member generally comprises a lumen having an inlet port and at least one outlet port for providing a flow pathway. The cutting means is mechanically connected to or is an integral part of the tubular member for creating an incision in the trabecular meshwork for receiving at least a portion of the tubular member.

In one embodiment, a self-trephining glaucoma stent is provided for reducing and/or balancing intraocular pressure in an eye. The stent generally comprises a snorkel and a curved blade. The snorkel generally comprises an upper seat for stabilizing the stent within the eye, a shank and a lumen. The shank is mechanically connected to the seat and is adapted for extending through a trabecular meshwork of the eye. The lumen extends through the snorkel and has at least one inlet flow port and at least one outlet flow port. The blade is mechanically connected to the snorkel. The blade generally comprises a cutting tip proximate a distal-most point of the blade for making an incision in the trabecular meshwork for receiving the shank.

Some embodiments disclosed herein relate to methods of implanting a trabecular stent device in an eye. In one embodiment, the device has a snorkel mechanically connected to a blade. The blade is advanced through a trabecular meshwork of the eye to cut the trabecular meshwork and form an incision therein. At least a portion of the snorkel is inserted in the incision to implant the device in the eye.

Some embodiments provide a self-trephining glaucoma stent and methods thereof which advantageously allow for a "one-step" procedure in which the incision and placement of the stent are accomplished by a single device and operation. This desirably allows for a faster, safer, and less expensive surgical procedure. In any of the embodiments, fiducial markings, indicia, or the like and/or positioning of the stent device in a preloaded applicator may be used for proper orientation and alignment of the device during implantation.

Among the advantages of trabecular bypass surgery is its simplicity. The microsurgery may potentially be performed on an outpatient basis with rapid visual recovery and greatly decreased morbidity. There is a lower risk of infection and choroidal hemorrhage, and there is a faster recovery, than with previous techniques.

Some embodiments disclosed herein relate to a medical device system for treating glaucoma of an eye comprising using OCT (optical coherence tomography) as an imaging and locating system for trabecular stent placement. In one embodiment, the procedure would first be set up with triangulation or some means to reliably establish the implant location in x, y, and z coordinates by using OCT within a few microns, most preferably in a non-invasive, non-contact manner. Having acquired the target space or location, the trabecular stent device would then be injected into place either via an ab interno procedure or an ab externo procedure. An article by Hoerauf et al. (Graefe's Arch Clin Exp Ophthalmol 2000; 238:8-18 published by Springer-Verlag), the entire contents

of which are incorporated herein by reference, discloses a slit-lamp adapted optical coherence tomography of the anterior segment.

Some embodiments disclosed herein relate to a “foldable” stent wherein the size of the stent is reduced in order to place it through a yet smaller ocular entrance wound, as small as half or less than the size of the unfolded stent. The small wound size aids in recovery, to reduce the likelihood of complications, and to reduce the preparation and extent of the surgical environment. In another embodiment, the device is positioned through the trabecular meshwork in an ab externo or ab interno procedure. Reliable visualization (OCT, UBM, gonioscope, electromagnetic or other means) is a key enabler for micro precision surgery such as a trabecular bypass surgery using a microstent.

Some embodiments disclosed herein relate to a medical device system with trephining capability, wherein a cutting mechanism is on or as part of the applicator for purposes of making the hole in trabecular meshwork for stent insertion. In one aspect, a cutting tip may protrude through the lumen of the stent. In another, the tip extends down the side of the snorkel without entering the lumen. In still another, the tip either passes through the lumen or down the side and further extends to the tip of the stent that is the leading edge during insertion. In one embodiment, the cutting tip can be designed to retract after making the incision but before insertion of the stent into Schlemm’s canal if it interferes with the insertion operation. It could also be retracted after insertion of the stent into Schlemm’s canal.

Some embodiments disclosed herein provide an implant for treating glaucoma, the implant having a longitudinal implant axis and comprising an outflow portion through which a portion of the longitudinal implant axis passes. The outflow portion is shaped and sized to be introduced into Schlemm’s canal with the portion of the longitudinal implant axis at an angle to Schlemm’s canal. The outflow portion is further shaped and sized to be received within Schlemm’s canal regardless of the rotational orientation of the outflow portion about the portion of the longitudinal implant axis during the introduction. The implant also comprises an inflow portion in fluid communication with the outflow portion, the inflow portion being configured to permit communication of fluid from the anterior chamber of the eye to the outflow portion.

Some embodiments disclosed herein provide an implant for treating glaucoma that comprises an outflow portion that is sized and shaped to be received within Schlemm’s canal. The outflow portion may comprise an outflow portion base having an outflow opening and at least one standoff member disposed to space the outflow opening from a wall of Schlemm’s canal, such that the opening is unobstructed by the canal wall.

Some embodiments disclosed herein provide an implant for treating glaucoma. The implant has a longitudinal implant axis and comprises a first portion at a first end of the longitudinal implant axis. The first portion is sized and configured to reside in Schlemm’s canal such that the first portion has a maximum dimension along a longitudinal axis of Schlemm’s canal that is not substantially greater than a dimension of the first portion that runs perpendicular to both the longitudinal axis of Schlemm’s canal and to the longitudinal implant axis. The implant also comprises a second portion at a second end of the longitudinal implant axis, the second portion being configured to provide fluid communication between the anterior chamber and the first portion.

Some embodiments disclosed herein provide an implant for treating glaucoma that comprises an outflow portion that

is sized and shaped to be received within Schlemm’s canal and an inflow portion that is in fluid communication with the outflow portion. The inflow portion is configured to be disposed in the anterior chamber of the eye. The implant also comprises a central portion extending between the inflow and outflow portions. The outflow portion has a diameter that is no more than three times the diameter of the central portion.

In accordance with one embodiment disclosed herein, an implant for treating glaucoma is provided. The implant includes a longitudinal implant axis, and comprises an outflow portion through which the longitudinal implant axis passes. The outflow portion is shaped and sized to be introduced into Schlemm’s canal with the portion of the longitudinal implant axis at an angle to Schlemm’s canal. The outflow portion is also shaped and sized to be received within Schlemm’s canal regardless of a rotational orientation of the outflow portion about the longitudinal implant axis during the introduction. The implant also comprises an inflow portion configured to permit communication of fluid from the anterior chamber of the eye to the outflow portion.

In accordance with another embodiment disclosed herein, an implant for treating glaucoma is provided. The implant comprises an outflow portion, sized and shaped to be received within Schlemm’s canal. The outflow portion comprises an outflow portion base having an outflow opening and at least one standoff member disposed to space the outflow opening from a wall of Schlemm’s canal, such that the outflow opening is unobstructed by the canal wall.

In accordance with a further embodiment disclosed herein, an implant for treating glaucoma is provided. The implant includes a longitudinal implant axis and comprises a first portion at a first end of the longitudinal implant axis. The first portion is sized and configured to reside in Schlemm’s canal, such that the first portion has a maximum dimension along a longitudinal axis of Schlemm’s canal that is not substantially greater than a dimension of the first portion that runs perpendicular to both the longitudinal axis of Schlemm’s canal and to the longitudinal implant axis. A second portion at a second end of the longitudinal implant axis is configured to provide fluid communication between the anterior chamber and the first portion.

In accordance with yet another embodiment disclosed herein, an implant for treating glaucoma comprises an outflow portion, sized and shaped to be received within Schlemm’s canal. An inflow portion is in fluid communication with the outflow portion, the inflow portion configured to be disposed in the anterior chamber of the eye. A central portion may extend between the inflow and outflow portions. The outflow portion having a diameter that is no more than three times the diameter of the central portion.

In accordance with yet another embodiment disclosed herein, an instrument for delivering implants for treating an ophthalmic condition is provided. The instrument comprises an elongate body sized to be introduced into an eye through an incision in the eye. A plurality of implants is positioned in the elongate body. The elongate body further comprises an actuator that serially dispenses the implants from the elongate body for implanting in eye tissue.

In accordance with another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method includes inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm’s canal at a first location, and utilizing the instrument to deliver a second implant through a wall of Schlemm’s canal at a second location, without removing the instrument from the eye between the deliveries of the implants.

In accordance with yet another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method includes inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm's canal at a first location, and utilizing the instrument to deliver a second implant through a wall of Schlemm's canal at a second location, wherein the locations are determined from morphological data on collector channel locations.

In accordance with yet another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm's canal at a first location, and utilizing the instrument to deliver a second implant through a wall of Schlemm's canal at a second location. The locations are determined by imaging collector channel locations.

In accordance with a further embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm's canal at a first location, and utilizing the instrument to deliver a second implant through a wall of Schlemm's canal at a second location. The locations are angularly spaced along Schlemm's canal by at least 20 degrees.

In accordance with yet another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm's canal at a first location, utilizing the instrument to deliver a second implant through a wall of Schlemm's canal at a second location. The first and second locations are substantially at collector channels.

In accordance with another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant through a wall of Schlemm's canal at a first location, and utilizing the instrument to deliver a second implant through a wall of Schlemm's canal at a second location. The implants have different flow characteristics.

In accordance with yet another embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises inserting an instrument into an eye through an incision, utilizing the instrument to deliver a first implant into the posterior segment of the eye, and utilizing the instrument to deliver a second implant into the posterior segment of the eye at a second location. The instrument is not removed from the eye between the deliveries of the implants.

In accordance with a further embodiment disclosed herein, a method of implanting a plurality of implants for treating glaucoma is provided. The method comprises serially dispensing a plurality of preloaded implants from an instrument into eye tissue at a respective plurality of locations within the eye.

In some embodiments, an implant for treating glaucoma is disclosed. The implant preferably comprises an inlet portion configured to be positioned in the anterior chamber of an eye and an outlet portion in fluid communication with the inlet portion, the outlet portion configured to be positioned at least partially in Schlemm's canal of the eye. The implant also

preferably comprises a scleral anchor extending from the outlet portion. The scleral anchor is configured to penetrate partially the sclera of the eye when the implant is positioned in the eye such that aqueous humor flows from the anterior chamber into the inlet portion, then into the outlet portion, and then into Schlemm's canal.

The implant may further comprise a stop that limits penetration of the implant through the sclera. For example, the stop may comprise a base of said outlet portion, an interface between the outlet portion and the scleral anchor, or at least one portion of said scleral anchor configured to radially extend into the sclera. Other means for limiting penetration of the implant through the sclera may also be used.

In some embodiments, the implant comprises a solid-walled tube having at least two ends. The tube may have multiple openings along a wall of said tube, the openings being spaced apart from the two ends. The tube may have a cross-sectional shape selected from the group consisting of a circle, an ellipse, a rectangle, a square, and a polygon. Other shapes may also be used.

In some embodiments, the scleral anchor may comprise a screw configured to penetrate partially the sclera. In further embodiments, the scleral anchor may comprise a sharp end, a conical shape, a screw, at least one protrusion, or a circumferential indentation.

In some embodiments, an implant for treating glaucoma is disclosed wherein the implant comprises an inlet portion that is configured to be positioned in the anterior chamber of an eye and an outlet portion in fluid communication with the inlet portion. The outlet portion is preferably configured to be positioned at least partially in Schlemm's canal of the eye. The outlet portion comprises a bulbous portion having at least two outlet openings along a surface of said bulbous portion, and the outlet openings are in fluid communication with the outlet and inlet portions.

In some embodiments the surface of the bulbous portion is polyhedral. In further embodiments, the bulbous portion has a shape that comprises at least part of a sphere or at least part of an ellipsoid. In a further embodiment, the bulbous portion is substantially hemispherical in shape.

For purposes of summarizing, certain aspects, advantages and novel features of the inventions disclosed herein have been described herein above. Of course, it is to be understood that not necessarily all such advantages may be achieved in accordance with any particular embodiment. Thus, the inventions may be embodied or carried out in a manner that achieves or optimizes one advantage or group of advantages as taught or suggested herein without necessarily achieving other advantages as may be taught or suggested herein.

These and other embodiments of the inventions will become apparent to those skilled in the art from the following detailed description of exemplary embodiments having reference to the attached figures, the inventions not being limited to any particular preferred embodiment(s) disclosed.

## BRIEF DESCRIPTION OF THE DRAWINGS

Certain preferred embodiments and modifications thereof will become apparent to those skilled in the art from the detailed description herein having reference to the figures that follow, of which:

FIG. 1 is a coronal cross-sectional view of an eye;

FIG. 2 is an enlarged cross-sectional view of an anterior chamber angle of the eye of FIG. 1 with a trabecular stent;

## 11

FIG. 3 is a schematic and partial sectional view of an eye illustrating an implanted glaucoma stent in accordance with one embodiment of at least one of the inventions disclosed herein;

FIG. 4 is a side elevational view of the stent of FIG. 3;

FIG. 5 is a top plan view of the stent of FIG. 3;

FIG. 6 is a bottom plan view of the stent of FIG. 3;

FIG. 7 is a front elevational view of the stent of FIG. 3 (along line 7-7 of FIG. 4);

FIG. 8 is a rear elevational view of the stent of FIG. 3 (along line 8-8 of FIG. 4);

FIG. 9 is an enlarged top plan view of a forward end of the stent of FIG. 3;

FIG. 10 is a top plan view of a modification of an inlet end of the stent of FIG. 3;

FIG. 11 is a top plan view of another modification of the inlet end of the stent of FIG. 3;

FIG. 12 is a top plan view of yet another modification of the inlet end of the stent of FIG. 3;

FIG. 13 is a top plan view of still another modification of the inlet end of the stent of FIG. 3;

FIG. 14 is schematic and partial sectional view of an eye illustrating a modification of the implanted glaucoma stent of FIG. 3;

FIG. 15 is a schematic and partial sectional view of an eye illustrating a further modification of the implanted glaucoma stent of FIG. 3;

FIG. 16 is a side elevational view of yet another modification of the glaucoma stent of FIG. 3;

FIG. 17 is a top plan view of the stent of FIG. 16;

FIG. 18 is a bottom plan view of the stent of FIG. 16;

FIG. 19 is a front elevational view along line 19-19 of FIG. 16;

FIG. 20 is a rear elevational view along line 20-20 of FIG. 16;

FIG. 21 is a side elevation view of still another modification of the glaucoma stent of FIG. 3;

FIG. 22 is a top plan view of the stent of FIG. 21;

FIG. 23 is a bottom plan view of the stent of FIG. 21;

FIG. 24 is a front elevational view along line 24-24 of FIG. 21;

FIG. 25 is a rear elevational view along line 25-25 of FIG. 21;

FIG. 26 is a front elevational view of a modification of the glaucoma stent illustrated in FIG. 3;

FIG. 27 is a right side elevational view of the stents illustrated in FIG. 26 as viewed along the line 27-27;

FIG. 28 is a right side elevational view of the glaucoma stent illustrated in FIG. 26, as viewed along the line 28-28;

FIG. 29 is a schematic and partial sectional view of an eye illustrating a temporal implantation of a glaucoma stent using a delivery apparatus having features and advantages in accordance with at least one of the inventions disclosed herein;

FIG. 30 is an oblique elevational view of an articulating arm stent delivery/retrieval apparatus having features and advantages in accordance with an embodiment of at least one of the inventions disclosed herein;

FIG. 31 is a schematic and partial sectional view of a portion of an eye and illustrating an implantation of a glaucoma stent using a delivery apparatus extending through the anterior chamber of the eye;

FIG. 32 is a schematic and partial sectional view of a Schlemm's canal and trabecular meshwork of an eye with another glaucoma stent extending from the anterior chamber of the eye, through the trabecular meshwork, and into a rear wall of the Schlemm's canal;

## 12

FIG. 33 is an enlarged cross-sectional view of a distal portion of the stent illustrated in FIG. 32;

FIG. 34 is a schematic and partial sectional view of the eye of FIG. 32 and a side elevational view of a modification of the stent illustrated in FIG. 32;

FIG. 35 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of a photo-modification of the stent illustrated in FIG. 32;

FIG. 36 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of another modification of the stent of FIG. 32;

FIG. 37 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of a further modification of the implant illustrated in FIG. 32;

FIG. 38 is a schematic and partial sectional view of the eye illustrated in FIG. 32 and a side elevational view of another modification of the stent illustrated in FIG. 32;

FIG. 39 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of the further modification of the implant illustrated in FIG. 32;

FIG. 40 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of yet another modification of the stent illustrated in FIG. 32;

FIG. 41 is a schematic and partial sectional view of an eye and the side elevational view of yet another modification of the stent illustrated in FIG. 32;

FIG. 42 is a schematic and partial sectional view of the eye illustrated in FIG. 32, and a side elevational view of yet another modification of the implant illustrated in FIG. 32;

FIG. 43 is an enlarged schematic and partial cross-sectional view of an anterior chamber angle of an eye having a valve stent implanted therein;

FIG. 44 is an enlarged cross-sectional view of an anterior chamber angle of an eye including an osmotic membrane device implanted therein;

FIG. 45 is an enlarged cross-sectional view of an anterior chamber angle of an eye illustrating an implantation of a glaucoma stent using an ab externo procedure;

FIG. 46 is a schematic and partial sectional view of the eye illustrated in FIG. 32 and a side elevational view of another modification of the implant illustrated in FIG. 32;

FIG. 47 is an enlarged schematic and partial sectional view of the eye illustrated in FIG. 32 and including a drug release device implanted therein;

FIG. 48 is a flow diagram illustrating a method for treating glaucoma;

FIG. 49A is an enlarged schematic illustration showing an anterior chamber, trabecular meshwork and a Schlemm's canal of an eye and an oblique elevational view of yet another modification of the stent illustrated in FIG. 32;

FIG. 49B is an oblique elevational view of a modification of the stent illustrated in FIG. 49A;

FIG. 49C is a side elevational view of another modification of the stent illustrated in FIG. 49A;

FIG. 50A is a cross-sectional view of the eye portion showing anatomically the trabecular meshwork, Schlemm's canal and one collector duct;

FIG. 50B is a cross-sectional view of FIG. 50A with a portion of a stent mechanically inserted into one of the collector ducts;

FIG. 51A is a side elevational view of a stent delivery applicator with a steerable distal section for multiple stent deployment;

FIG. 51B is a schematic and partial sectional view of the distal section of the stent delivery applicator of FIG. 51A;

FIG. 51C is a cross-sectional view, section 1-1 of FIG. 51B;

## 13

FIG. 51D is an oblique side elevational view of the steerable section of the delivery applicator illustrated in FIG. 51A and including an optional ultrasonically enabled distal end;

FIG. 52A is a partial sectional and side elevational view of a distal section of a modification of the stent delivery applicator illustrated in FIG. 51A;

FIG. 52B is a partial sectional and side elevational view of a distal section of the stent delivery applicator illustrated in FIG. 51A having been inserted through a trabecular meshwork with the stent disposed within the distal section;

FIG. 52C is a partial sectional and side elevational view of a distal section of the stent delivery applicator illustrated in FIG. 51A having been inserted through a trabecular meshwork and after the sheath of the distal portion has been withdrawn;

FIG. 52D is a partial sectional and side elevational view of a distal section of the stent delivery applicator illustrated in FIG. 51A having been inserted through a trabecular meshwork, and after the sheath and a cutting member have been withdrawn;

FIG. 53 is an oblique side elevational and partial sectional view of a further modification of the stent illustrated in FIG. 32;

FIG. 54A is a sectional view of yet another modification of the stent delivery applicator illustrated in FIG. 51A;

FIG. 54B is an enlarged sectional view of a distal end of the applicator illustrated in FIG. 54A and including two implants disposed over a trocar of the device, this portion being identified by the circle 2-2 in FIG. 54A;

FIG. 54C is a sectional view of the applicator device taken along section line 3-3 of FIG. 54A;

FIGS. 55 A-C show multiple views of an embodiment of a trabecular stent.

FIGS. 56 A-B show multiple views of another embodiment of a trabecular stent;

FIGS. 57 A-B show multiple views of a trabecular stent having a modified center bulb with anchors;

FIGS. 58 A-B show multiple views of another embodiment of a trabecular stent;

FIGS. 59 A-C show multiple views of another embodiment of a trabecular stent;

FIGS. 60 A-B show multiple views of another embodiment of a trabecular stent with scleral anchors;

FIGS. 61 A-B show multiple views of another embodiment of a trabecular stent with scleral anchors;

FIGS. 62 A-B show multiple views of a trabecular stent with screws;

FIGS. 63 A-B show multiple views of another embodiment of a trabecular stent;

FIGS. 64 A-B show a dual blade mushroom stent and its associated trocar delivery system;

FIG. 65 shows a perspective view of a G2 injector;

FIG. 66 shows a top view of the G2 injector of FIG. 65;

FIG. 67 shows a side cross-sectional view of a G2 injector stem, showing solid trocar portion;

FIGS. 68 A-C show three modes of a side cross-sectional view of a G2 injector stem, showing irrigating trocar portion;

FIG. 69 shows two modes of the G2 injector (A) in the cocked orientation; (B) in the deployed orientation;

FIGS. 70 A and B show two pusher tube locations of the button geometry;

FIG. 71 shows a schematic of effective shorting of a pusher tube in the G2 injector; and

FIG. 72 illustrates where the pusher-tube resides when the G2 injector is cocked.

## 14

## DETAILED DESCRIPTION OF EXEMPLARY EMBODIMENTS

The preferred embodiments described herein relate particularly to surgical and therapeutic treatment of glaucoma through reduction of intraocular pressure and/or stimulation of the trabecular meshwork tissue. While the description sets forth various embodiment-specific details, it will be appreciated that the description is illustrative only and should not be construed in any way as limiting the inventions disclosed herein. Furthermore, various applications of the inventions disclosed herein, and modifications thereto, which may occur to those who are skilled in the art, are also encompassed by the general concepts described herein.

FIG. 1 is a cross-sectional view of an eye 10. FIG. 2 is an enlarged sectional view of the eye showing the relative anatomical locations of a trabecular meshwork 21, an anterior chamber 20, and a Schlemm's canal 22. A sclera 11 is a thick collagenous tissue which covers the entire eye 10 except a portion which is covered by a cornea 12.

With reference to FIGS. 1 and 2, the cornea 12 is a thin transparent tissue that focuses and transmits light into the eye and through a pupil 14, which is a circular hole in the center of an iris 13 (colored portion of the eye). The cornea 12 merges into the sclera 11 at a juncture referred to as a limbus 15. A ciliary body 16 extends along the interior of the sclera 11 and is coextensive with a choroid 17. The choroid 17 is a vascular layer of the eye 10, located between the sclera 11 and a retina 18. An optic nerve 19 transmits visual information to the brain and is the anatomic structure that is progressively destroyed by glaucoma.

With continued reference to FIGS. 1 and 2, the anterior chamber 20 of the eye 10, which is bound anteriorly by the cornea 12 and posteriorly by the iris 13 and a lens 26, is filled with aqueous humor (hereinafter referred to as "aqueous"). Aqueous is produced primarily by the ciliary body 16, then moves anteriorly through the pupil 14 and reaches an anterior chamber angle 25, formed between the iris 13 and the cornea 12.

As best illustrated by the drawing of FIG. 2, in a normal eye, aqueous is removed from the anterior chamber 20 through the trabecular meshwork 21. Aqueous passes through the trabecular meshwork 21 into Schlemm's canal 22 and thereafter through a plurality of collector ducts and aqueous veins 23, which merge with blood-carrying veins, and into systemic venous circulation. Intraocular pressure is maintained by an intricate balance between secretion and outflow of aqueous in the manner described above. Glaucoma is, in most cases, characterized by an excessive buildup of aqueous in the anterior chamber 20 which leads to an increase in intraocular pressure. Fluids are relatively incompressible, and thus intraocular pressure is distributed relatively uniformly throughout the eye 10.

As shown in FIG. 2, the trabecular meshwork 21 is adjacent a small portion of the sclera 11. Exterior to the sclera 11 is a conjunctiva 24. Traditional procedures that create a hole or opening for implanting a device through the tissues of the conjunctiva 24 and sclera 11 involve extensive surgery, as compared to surgery for implanting a device, as described herein, which ultimately resides entirely within the confines of the sclera 11 and cornea 12. A trabecular stent 229 can be placed bypassing the trabecular meshwork 21 with a proximal terminal 227 exposed to anterior chamber 20 and a distal terminal 228 exposed to Schlemm's canal 22.

FIG. 3 schematically illustrates the use of one embodiment of a trabecular stenting device 30 for establishing an outflow pathway, passing through the trabecular meshwork 21,



## 15

described in greater detail below. FIGS. 4-9 are different views of the stent 30. Advantageously, and as discussed in further detail later herein, a self-trephining stent allows a one-step procedure to make an incision in the trabecular mesh 21 and place the stent or implant 30 at the desired or predetermined position within the eye 10. Desirably, this facilitates and simplifies the overall surgical procedure.

In the illustrated embodiment of FIGS. 3-9, the shunt or stent 30 generally comprises an inlet portion or "snorkel" 32 and a main body portion or blade 34. The snorkel 32 and blade 34 are mechanically connected to or in mechanical communication with one another. A generally longitudinal axis 36 extends along the stent 30 and/or the body portion 34.

In the illustrated embodiment of FIGS. 3-9, the stent 30 comprises an integral unit. In modified embodiments, the stent 30 may comprise an assembly of individual pieces or components. For example, the stent 30 may comprise an assembly of the snorkel 32 and blade 34.

In the illustrated embodiment of FIGS. 3-9, the snorkel 32 is in the form of a generally elongate tubular member and generally comprises an upper seat, head or cap portion 38, a shank portion 40 and a lumen or passage 42 extending there-through. The seat 38 is mechanically connected to or in mechanical communication with the shank 40 which is also mechanically connected to or in mechanical communication with the blade 34. Longitudinal axis 43 extends along the snorkel 32 and/or the lumen 42.

In the illustrated embodiment of FIGS. 3-9, the seat 38 is generally circular in shape and has an upper surface 44 and a lower surface 46 which, as shown in FIG. 3, abuts or rests against the trabecular meshwork 21 to stabilize the glaucoma stent 30 within the eye 10. In modified embodiments, the seat 38 may efficaciously be shaped in other suitable manners, as required or desired, giving due consideration to the goals of stabilizing the glaucoma stent 30 within the eye 10 and/or of achieving one or more of the benefits and advantages as taught or suggested herein. For example, the seat 38 may be shaped in other polygonal or non-polygonal shapes and/or comprise one or more ridges which extend radially outwards, among other suitable retention devices.

In the illustrated embodiment of FIGS. 3-9, and as best seen in the top view of FIG. 5, the seat top surface 44 comprises fiducial marks or indicia 48. These marks or indicia 48 facilitate and ensure proper orientation and alignment of the stent 30 when implanted in the eye 10. The marks or indicia 48 may comprise visual differentiation means such as color contrast or be in the form of ribs, grooves, or the like. Alternatively, or in addition, the marks 48 may provide tactile sensory feedback to the surgeon by incorporating a radio-paque detectable or ultrasound imaginable substrate at about the mark 48. Also, the seat 38 and/or the seat top surface 44 may be configured in predetermined shapes aligned with the blade 34 and/or longitudinal axis 36 to provide for proper orientation of the stent device 30 within the eye 10. For example, the seat top surface 44 may be oval or ellipsoidal (FIG. 10), rectangular (FIG. 11), hexagonal (FIG. 12), among other suitable shapes (e.g. FIG. 13).

In the illustrated embodiment of FIGS. 3-9, and as indicated above, the seat bottom surface 46 abuts or rests against the trabecular meshwork 21 to stabilize and retain the glaucoma stent 30 within the eye 10. For stabilization purposes, the seat bottom surface 46 may comprise a stubbed surface, a ribbed surface, a surface with pillars, a textured surface, or the like.

In the illustrated embodiment of FIGS. 3-9, the snorkel shank 40 is generally cylindrical in shape. With the stent 30 implanted, as shown in FIG. 3, the shank 40 is generally

## 16

positioned in an incision or cavity 50 formed in the trabecular meshwork 21 by the self-trephining stent 30. Advantageously, and as discussed further below, this single step of forming the cavity 50 by the stent 30 itself and placing the stent 30 in the desired position facilitates and expedites the overall surgical procedure. In modified embodiments, the snorkel shank 40 may efficaciously be shaped in other suitable manners, as required or desired. For example, the shank 40 may be in the shape of other polygonal or non-polygonal shapes, such as, oval, ellipsoidal, and the like.

In the illustrated embodiment of FIGS. 3-9, and as best seen in FIG. 3, the shank 40 has an outer surface 52 in contact with the trabecular meshwork 21 surrounding the cavity 50. For stabilization purposes, the shank outer surface 52 may comprise a stubbed surface, a ribbed surface, a surface with pillars, a textured surface, or the like.

In the illustrated embodiment of FIGS. 3-9, the snorkel lumen 42 has an inlet port, opening or orifice 54 at the seat top surface 44 and an outlet port, opening or orifice 56 at the junction of the shank 40 and blade 34. The lumen 42 is generally cylindrical in shape, that is, it has a generally circular cross-section, and its ports 54, 56 are generally circular in shape. In modified embodiments, the lumen 42 and ports 54, 56 may be efficaciously shaped in other manners, as required or desired, giving due consideration to the goals of providing sufficient aqueous outflow and/or of achieving one or more of the benefits and advantages as taught or suggested herein. For example, the lumen 42 and/or one or both ports 54, 56 may be shaped in the form of ovals, ellipsoids, and the like, or the lumen 42 may have a tapered or stepped configuration.

Referring in particular to FIG. 3, aqueous from the anterior chamber 20 flows into the lumen 42 through the inlet port 54 (as generally indicated by arrow 58) and out of the outlet port 56 and into Schlemm's canal 22 (as generally indicated by arrows 60) to lower and/or balance the intraocular pressure (TOP). In another embodiment, as discussed in further detail below, one or more of the outlet ports may be configured to face in the general direction of the stent longitudinal axis 36. In modified embodiments, the snorkel 32 may comprise more than one lumen, as needed or desired, to facilitate multiple aqueous outflow transportation into Schlemm's canal 22.

In the illustrated embodiment of FIGS. 3-9, the blade longitudinal axis 36 and the snorkel longitudinal axis 43 are generally perpendicular to one another. Stated differently, the projections of the axes 36, 43 on a common plane which is not perpendicular to either of the axes 36, 43 intersect at 90°. The blade longitudinal axis 36 and the snorkel longitudinal axis 43 may intersect one another or may be offset from one another.

In the illustrated embodiment of FIGS. 3-9, the main body portion or blade 34 is a generally curved elongated sheet- or plate-like structure with an upper curved surface 62 and a lower curved surface 64 which defines a trough or open face channel 66. The perimeter of the blade 34 is generally defined by a curved proximal edge 68 proximate to the snorkel 32, a curved distal edge 70 spaced from the proximal edge 68 by a pair of generally straight lateral edges 72, 74. The first lateral edge 72 extends beyond the second lateral edge 74 and intersects with the distal edge 70 at a distal-most point 76 of the blade 34. Preferably, the blade 34 defines a blade cutting tip 78.

In the illustrated embodiment of FIGS. 3-9, and as shown in the enlarged view of FIG. 9, the cutting tip 78 comprises a first cutting edge 80 on the distal edge 70 and a second cutting edge 82 on the lateral edge 72. The cutting edges 80, 82 preferably extend from the distal-most point 76 of the blade 34 and comprise at least a respective portion of the distal edge 70 and lateral edge 72. The respective cutting edges 80, 82 are

formed at the sharp edges of respective beveled or tapered surfaces **84**, **86**. In one embodiment, the remainder of the distal edge **70** and lateral edge **72** are dull or rounded. In one embodiment, the tip **78** proximate to the distal-most end **76** is curved slightly inwards, as indicated generally by the arrow **88** in FIG. **5** and arrow **88** (pointed perpendicular and into the plane of the paper) in FIG. **9**, relative to the adjacent curvature of the blade **34**.

In modified embodiments, suitable cutting edges may be provided on selected portions of one or more selected blade edges **68**, **70**, **72**, **74** with efficacy, as needed or desired, giving due consideration to the goals of providing suitable cutting means on the stent **30** for effectively cutting through the trabecular meshwork **21** (FIG. **3**) and/or of achieving one or more of the benefits and advantages as taught or suggested herein.

Referring in particular to FIG. **9**, in one embodiment, the ratio between the lengths of the cutting edges **80**, **82** is about 2:1. In another embodiment, the ratio between the lengths of the cutting edges **80**, **82** is about 1:1. In yet another embodiment, the ratio between the lengths of the cutting edges **80**, **82** is about 1:2. In modified embodiments, the lengths of the cutting edges **80**, **82** may be efficaciously selected in other manners, as required or desired, giving due consideration to the goals of providing suitable cutting means on the stent **30** for effectively cutting through the trabecular meshwork **21** (FIG. **3**) and/or of achieving one or more of the benefits and advantages as taught or suggested herein.

Still referring in particular to FIG. **9**, in one embodiment, the ratio between the lengths of the cutting edges **80**, **82** is in the range from about 2:1 to about 1:2. In another embodiment, the ratio between the lengths of the cutting edges **80**, **82** is in the range from about 5:1 to about 1:5. In yet another embodiment, the ratio between the lengths of the cutting edges **80**, **82** is in the range from about 10:1 to about 1:10. In modified embodiments, the lengths of the cutting edges **80**, **82** may be efficaciously selected in other manners, as required or desired, giving due consideration to the goals of providing suitable cutting means on the stent **30** for effectively cutting through the trabecular meshwork **21** (FIG. **3**) and/or of achieving one or more of the benefits and advantages as taught or suggested herein.

As shown in the top view of FIG. **9**, the cutting edge **80** (and/or the distal end **70**) and the cutting edge **82** (and/or the lateral edge **72**) intersect at an angle  $\theta$ . Stated differently,  $\theta$  is the angle between the projections of the cutting edge **80** (and/or the distal end **70**) and the cutting edge **82** (and/or the lateral edge **72**) on a common plane which is not perpendicular to either of these edges.

Referring to in particular to FIG. **9**, in one embodiment, the angle  $\theta$  is about  $50^\circ$ . In another embodiment, the angle  $\theta$  is in the range from about  $40^\circ$  to about  $60^\circ$ . In yet another embodiment, the angle  $\theta$  is in the range from about  $30^\circ$  to about  $70^\circ$ . In modified embodiments, the angle  $\theta$  may be efficaciously selected in other manners, as required or desired, giving due consideration to the goals of providing suitable cutting means on the stent **30** for effectively cutting through the trabecular meshwork **21** (FIG. **3**) and/or of achieving one or more of the benefits and advantages as taught or suggested herein.

The stent **30** of the embodiments disclosed herein can be dimensioned in a wide variety of manners. Referring in particular to FIG. **3**, the depth of Schlemm's canal **22** is typically about less than 400 microns ( $\mu\text{m}$ ). Accordingly, the stent blade **34** is dimensioned so that the height of the blade **34** (referred to as  $H_{41}$  in FIG. **4**) is typically less than about 400  $\mu\text{m}$ . The snorkel shank **40** is dimensioned so that it has a length (referred to as  $L_{41}$  in FIG. **4**) typically in the range from

about 150  $\mu\text{m}$  to about 400  $\mu\text{m}$  which is roughly the typical range of the thickness of the trabecular meshwork **21**.

Of course, as the skilled artisan will appreciate, that with the stent **30** implanted, the blade **34** may rest at any suitable position within Schlemm's canal **22**. For example, the blade **34** may be adjacent to a front wall **90** of Schlemm's canal **22** (as shown in FIG. **3**), or adjacent to a back wall **92** of Schlemm's canal **22**, or at some intermediate location therebetween, as needed or desired. Also, the snorkel shank **40** may extend into Schlemm's canal **22**. The length of the snorkel shank **40** and/or the dimensions of the blade **34** may be efficaciously adjusted to achieve the desired implant positioning.

The trabecular stenting device **30** (FIGS. **3-9**) of the exemplary embodiment may be manufactured or fabricated by a wide variety of techniques. These include, without limitation, molding, thermo-forming, or other micro-machining techniques, among other suitable techniques.

The trabecular stenting device **30** preferably comprises a biocompatible material such that inflammation arising due to irritation between the outer surface of the device **30** and the surrounding tissue is minimized. Biocompatible materials which may be used for the device **30** preferably include, but are not limited to, titanium, titanium alloys, medical grade silicone, e.g., SILASTIC™, available from Dow Corning Corporation of Midland, Mich.; and polyurethane, e.g., PELLETANET™, also available from Dow Corning Corporation.

In other embodiments, the stent device **30** may comprise other types of biocompatible material, such as, by way of example, polyvinyl alcohol, polyvinyl pyrrolidone, collagen, heparinized collagen, polytetrafluoroethylene, expanded polytetrafluoroethylene, fluorinated polymer, fluorinated elastomer, flexible fused silica, polyolefin, polyester, polysilicon, and/or a mixture of the aforementioned biocompatible materials, and the like. In still other embodiments, composite biocompatible material may be used, wherein a surface material may be used in addition to one or more of the aforementioned materials. For example, such a surface material may include polytetrafluoroethylene (PTFE) (such as TEFLON™), polyimide, hydrogel, heparin, therapeutic drugs (such as beta-adrenergic antagonists and other anti-glaucoma drugs, or antibiotics), and the like.

In an exemplary embodiment of the trabecular meshwork surgery, the patient is placed in the supine position, prepped, draped and anesthetized as necessary. A small (less than about 1 mm) incision, which may be self sealing can then be made through the cornea **12**. The corneal incision can be made in a number of ways, for example, by using a micro-knife, among other tools.

An applicator or delivery apparatus is used to advance the glaucoma stent **30** through the corneal incision and to the trabecular meshwork **21**. Some embodiments of such a delivery apparatus are disclosed in U.S. application Ser. No. 10/101,548, filed Mar. 18, 2002, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT, and U.S. Provisional Application No. 60/276,609, filed Mar. 16, 2001, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT, the entire contents of each one of which are hereby incorporated by reference herein. Some embodiments of a delivery apparatus are also described in further detail below. Gonioscopic, microscopic, or endoscopic guidance can be used during the trabecular meshwork surgery.

With the device **30** held by the delivery apparatus, the blade **34** of the device **30** is used to cut and/or displace the material

19

of the trabecular meshwork **21**. The snorkel shank **40** can also facilitate in removal of this material during implantation. The delivery apparatus is withdrawn once the device **30** has been implanted in the eye **10**. As shown in FIG. 3, the snorkel seat **38** can rest on a top surface **94** of the trabecular meshwork **21** with the snorkel shank **40** extending through the cavity **50** (created by the device **30**) in the trabecular meshwork **21**, and with the blade **34** extending inside Schlemm's canal **22**.

Advantageously, the embodiments of the self-trephining stent device **30** allow for a "one-step" procedure to make an incision in the trabecular meshwork and to implant the stent in the proper orientation and alignment within the eye to allow outflow of aqueous from the anterior chamber through the stent and into Schlemm's canal to lower and/or balance the intraocular pressure (IOP). Desirably, this provides for a faster, safer, and less expensive surgical procedure.

Many complications can arise in trabecular meshwork surgeries, wherein a knife is first used to create an incision in the trabecular meshwork, followed by removal of the knife and subsequent installation of the stent. For instance, the knife may cause some bleeding which clouds up the surgical site. This may require more effort and time to clean the surgical site prior to placement of the stent. Moreover, this may cause the intraocular pressure (IOP) to rise or to fall undesirably. Thus, undesirably, such a multiple step procedure may demand crisis management which slows down the surgery, makes it less safe, and more expensive.

FIG. 14 is a simplified partial view of an eye **10** illustrating the implantation of a self-trephining glaucoma stent device **30a** having features and advantages in accordance with one embodiment. The stent **30a** is generally similar to the stent **30** of FIGS. 3-9 except that its snorkel **32a** comprises a longer shank **40a** which extends into Schlemm's canal **22** and a lumen **42a** which bifurcates into two output channels **45a**.

In the illustrated embodiment of FIG. 14, the shank **40a** terminates at the blade **34**. Aqueous flows from the anterior chamber **20** into the lumen **42a** through an inlet port **54a** (as generally indicated by arrow **58a**). Aqueous then flows through the output channels **45a** and out of respective outlet ports **56a** and into Schlemm's canal **22** (as generally indicated by arrows **60a**). The outlet channels **45a** extend radially outwards in generally opposed directions and the outlet ports **56a** are configured to face in the general direction of the stent longitudinal axis **36** so that they open into Schlemm's canal **22** and are in proper orientation to allow aqueous outflow into Schlemm's canal **22** for lowering and/or balancing the intraocular pressure (IOP). As indicated above, fiducial marks or indicia and/or predetermined shapes of the snorkel seat **38** allow for proper orientation of the blade **34** and also the output channels **45a** and respective ports **56a** within Schlemm's canal.

In the illustrated embodiment of FIG. 14, two outflow channels **45a** are provided. In another embodiment, only one outflow channel **45a** is provided. In yet another embodiment, more than two outflow channels **45a** are provided. In modified embodiments, the lumen **42a** may extend all the way through to the blade **34** and provide an outlet port as discussed above with reference to the embodiment of FIGS. 3-9.

FIG. 15 is a simplified partial view of an eye **10** illustrating the implantation of a self-trephining glaucoma stent device **30b** having features and advantages in accordance with one embodiment. The stent **30b** is generally similar to the stent **30** of FIGS. 3-9 except that its snorkel **32b** comprises a longer shank **40b** which extends into Schlemm's canal **22** and a lumen **42b** which bifurcates into two output channels **45b**.

In the illustrated embodiment of FIG. 15, the shank **40b** extends through the blade **34**. Aqueous flows from the ante-

20

rior chamber **20** into the lumen **42b** through an inlet port **54b** (as generally indicated by arrow **58b**). Aqueous then flows through the output channels **45b** and out of respective outlet ports **56b** and into Schlemm's canal **22** (as generally indicated by arrows **60b**). The outlet channels **45b** extend radially outwards in generally opposed directions and the outlet ports **56b** are configured to face in the general direction of the stent longitudinal axis **36** so that they open into Schlemm's canal **22** and are in proper orientation to allow aqueous outflow into Schlemm's canal **22** for lowering and/or balancing the intraocular pressure (IOP). As indicated above, fiducial marks or indicia and/or predetermined shapes of the snorkel seat **38** allow for proper orientation of the blade **34** and also the output channels **45b** and respective ports **56b** within Schlemm's canal.

In the illustrated embodiment of FIG. 15, two outflow channels **45b** are provided. In another embodiment, only one outflow channel **45b** is provided. In yet another embodiment, more than two outflow channels **45b** are provided. In modified embodiments, the lumen **42b** may extend all the way through to the blade **34** and provide an outlet port as discussed above with reference to the embodiment of FIGS. 3-9.

FIGS. 16-20 show different views of a self-trephining glaucoma stent device **30c** having features and advantages in accordance with one embodiment. The stent **30c** is generally similar to the stent **30** of FIGS. 3-9 except that it has a modified blade configuration. The stent **30c** comprises a blade **34c** which is a generally curved elongated sheet- or plate-like structure with an upper curved surface **62c** and a lower curved surface **64c** which defines a trough or open face channel **66c**. The perimeter of the blade **34c** is generally defined by a curved proximal edge **68c** proximate to the snorkel **32**, a curved distal edge **70c** spaced from the proximal edge **68c** by a pair of generally straight lateral edges **72c**, **74c** which are generally parallel to one another and have about the same length.

In the illustrated embodiment of FIGS. 16-20, the blade **34c** comprises a cutting tip **78c**. The cutting tip **78c** preferably includes cutting edges formed on selected portions of the distal edge **70c** and adjacent portions of the lateral edges **72c**, **74c** for cutting through the trabecular meshwork for placement of the snorkel **32**. The cutting edges are sharp edges of beveled or tapered surfaces as discussed above in reference to FIG. 9. The embodiment of FIGS. 16-20 may be efficaciously modified to incorporate the snorkel configuration of the embodiments of FIGS. 14 and 15.

FIGS. 21-25 show different views of a self-trephining glaucoma stent device **30d** having features and advantages in accordance with one embodiment. The stent **30d** is generally similar to the stent **30** of FIGS. 3-9 except that it has a modified blade configuration. The stent **30d** comprises a blade **34d** which is a generally curved elongated sheet- or plate-like structure with an upper curved surface **62d** and a lower curved surface **64d** which defines a trough or open face channel **66d**. The perimeter of the blade **34d** is generally defined by a curved proximal edge **68d** proximate to the snorkel **32**, a pair of inwardly converging curved distal edges **70d**, **70d''** spaced from the proximal edge **68d** by a pair of generally straight respective lateral edges **72d**, **74d** which are generally parallel to one another and have about the same length. The distal edges **70d**, **70d''** intersect at a distal-most point **76d** of the blade **34d** proximate a blade cutting tip **78d**.

In the illustrated embodiment of FIGS. 21-25, the cutting tip **78d** preferably includes cutting edges formed on the distal edges **70d**, **70d''** and extending from the distal-most point **76d** of the blade **34d**. In one embodiment, the cutting edges extend along only a portion of respective distal edges **70d**, **70d''**. In

## 21

another embodiment, the cutting edges extend along substantially the entire length of respective distal edges **70d'**, **70d''**. In yet another embodiment, at least portions of the lateral edges **72d**, **74d** proximate to respective distal edges **70d'**, **70d''** have cutting edges. In a further embodiment, the tip **78d** proximate to the distal-most end **76d** is curved slightly inwards, as indicated generally by the arrow **88d** in FIG. 21 and arrow **88d** (pointed perpendicular and into the plane of the paper) in FIG. 22, relative to the adjacent curvature of the blade **34d**.

In the embodiment of FIGS. 21-25, the cutting edges are sharp edges of beveled or tapered surfaces as discussed above in reference to FIG. 9. The embodiment of FIGS. 21-25 may be efficaciously modified to incorporate the snorkel configuration of the embodiments of FIGS. 14 and 15.

FIGS. 26-28 show different views of a self-trephining glaucoma stent device **30e** having features and advantages in accordance with one embodiment. The stent device **30e** generally comprises a snorkel **32e** mechanically connected to or in mechanical communication with a blade or cutting tip **34e**. The snorkel **32e** has a seat, head or cap portion **38e** mechanically connected to or in mechanical communication with a shank **40e**, as discussed above. The shank **40e** has a distal end or base **47e**. The snorkel **32e** further has a lumen **42e** which bifurcates into a pair of outlet channels **45e**, as discussed above in connection with FIGS. 14 and 15. Other lumen and inlet and outlet port configurations as taught or suggested herein may also be efficaciously used, as needed or desired.

In the illustrated embodiment of FIGS. 26-28, the blade **34e** extends downwardly and outwardly from the shank distal end **47e**. The blade **34e** is angled relative to a generally longitudinal axis **43e** of the snorkel **32e**, as best seen in FIGS. 27 and 28. The blade **34e** has a distal-most point **76e**. The blade or cutting tip **34e** has a pair of side edges **70e'**, **70e''**, including cutting edges, terminating at the distal-most point **76e**, as best seen in FIG. 26. In one embodiment, the cutting edges are sharp edges of beveled or tapered surfaces as discussed above in reference to FIG. 9.

Referring to FIGS. 26-28, in one embodiment, the blade **34e** includes cutting edges formed on the edges **70e'**, **70e''** and extending from the distal-most point **76e** of the blade **34d**. In one embodiment, the cutting edges extend along only a portion of respective distal edges **70e'**, **70e''**. In another embodiment, the cutting edges extend along substantially the entire length of respective distal edges **70e'**, **70e''**. In yet another embodiment, the blade or cutting tip **34e** comprises a bent tip of needle, for example, a 30 gauge needle.

In general, any of the blade configurations disclosed herein may be used in conjunction with any of the snorkel configurations disclosed herein or incorporated by reference herein to provide a self-trephining glaucoma stent device for making an incision in the trabecular meshwork for receiving the corresponding snorkel to provide a pathway for aqueous outflow from the eye anterior chamber to Schlemm's canal, thereby effectively lowering and/or balancing the intraocular pressure (IOP). The self-trephining ability of the device, advantageously, allows for a "one-step" procedure in which the incision and placement of the snorkel are accomplished by a single device and operation. In any of the embodiments, fiducial markings or indicia, and/or preselected configuration of the snorkel seat, and/or positioning of the stent device in a preloaded applicator may be used for proper orientation and alignment of the device during implantation.

In many cases, a surgeon works from a temporal incision when performing cataract or goniotomy surgery. FIG. 29 illustrates a temporal implant procedure, wherein a delivery apparatus or "applicator" **100** having a curved tip **102** is used to deliver a stent **30** to a temporal side **27** of the eye **10**. An

## 22

incision **28** is made in the cornea **10**, as discussed above. The apparatus **100** is then used to introduce the stent **30** through the incision **28** and implant it within the eye **10**.

Still referring in particular to FIG. 29, in one embodiment, a similarly curved instrument would be used to make the incision through the trabecular meshwork **21**. In other embodiments, a self-trephining stent device **30** may be used to make this incision through the trabecular meshwork **21**, as discussed above. The temporal implantation procedure illustrated in FIG. 29 may be employed with the any of the various stent embodiments taught or suggested herein.

FIG. 30 illustrates one embodiment of an apparatus comprising an articulating stent applicator or retrieval device **100a**. In this embodiment, a proximal arm **106** is attached to a distal arm **108** at a joint **112**. This joint **112** is movable such that an angle formed between the proximal arm **106** and the distal arm **108** can change. One or more claws **114** can extend from the distal arm **108**, in the case of a stent retrieval device. Similarly, this articulation mechanism may be used for the trabecular stent applicator, and thus the articulating applicator or retrieval device **100a** may be either an applicator for the trabecular stent, a retrieval device, or both, in various embodiments. The embodiment of FIG. 30 may be employed with the any of the various stent embodiments taught or suggested herein.

FIG. 31 shows another illustrative method for placing any of the various stent embodiments taught or suggested herein at the implant site within the eye **10**. A delivery apparatus **100b** generally comprises a syringe portion **116** and a cannula portion **118**. The distal section of the cannula **118** has at least one irrigating hole **120** and a distal space **122** for holding the stent device **30**. The proximal end **124** of the lumen of the distal space **122** is sealed from the remaining lumen of the cannula portion **118**. The delivery apparatus of FIG. 30 may be employed with the any of the various stent embodiments taught or suggested herein.

In one embodiment of the invention, a delivery apparatus (or "applicator") is used for placing a trabecular stent through a trabecular meshwork of an eye. Certain embodiments of such a delivery apparatus are disclosed in U.S. application Ser. No. 10/101,548, filed Mar. 18, 2002, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT, and U.S. Provisional Application No. 60/276,609, filed Mar. 16, 2001, entitled APPLICATOR AND METHODS FOR PLACING A TRABECULAR SHUNT FOR GLAUCOMA TREATMENT.

The stent has an inlet section and an outlet section. The delivery apparatus includes a handpiece, an elongate tip, a holder and an actuator. The handpiece has a distal end and a proximal end. The elongate tip is connected to the distal end of the handpiece. The elongate tip has a distal portion and is configured to be placed through a corneal incision and into an anterior chamber of the eye. The holder is attached to the distal portion of the elongate tip. The holder is configured to hold and release the inlet section of the trabecular stent. The actuator is on the handpiece and actuates the holder to release the inlet section of the trabecular stent from the holder. When the trabecular stent is deployed from the delivery apparatus into the eye, the outlet section is positioned in substantially opposite directions inside Schlemm's canal. In one embodiment, a deployment mechanism within the delivery apparatus includes a push-pull type plunger.

In some embodiments, the holder comprises a clamp. In some embodiments, the apparatus further comprises a spring within the handpiece that is configured to be loaded when the stent is being held by the holder, the spring being at least

partially unloaded upon actuating the actuator, allowing for release of the stent from the holder.

In various embodiments, the clamp comprises a plurality of claws configured to exert a clamping force onto the inlet section of the stent. The holder may also comprise a plurality of flanges.

In some embodiments, the distal portion of the elongate tip is made of a flexible material. This can be a flexible wire. The distal portion can have a deflection range, preferably of about 45 degrees from the long axis of the handpiece. The delivery apparatus can further comprise an irrigation port in the elongate tip.

Some embodiments include a method of placing a trabecular stent through a trabecular meshwork of an eye, the stent having an inlet section and an outlet section, including advancing a delivery apparatus holding the trabecular stent through an anterior chamber of the eye and into the trabecular meshwork, placing part of the stent through the trabecular meshwork and into a Schlemm's canal of the eye; and releasing the stent from the delivery apparatus.

In some embodiments, the method includes using a delivery apparatus that comprises a handpiece having a distal end and a proximal end and an elongate tip connected to the distal end of the handpiece. The elongate tip has a distal portion and being configured to be placed through a corneal incision and into an anterior chamber of the eye. The apparatus further has a holder attached to the distal portion of the elongate tip, the holder being configured to hold and release the inlet section of the trabecular stent, and an actuator on the handpiece that actuates the holder to release the inlet section of the trabecular stent from the holder.

In one embodiment, the trabecular stent is removably attached to a delivery apparatus (also known as "applicator"). When the trabecular stent is deployed from the delivery apparatus into the eye, the outlet section is positioned in substantially opposite directions inside Schlemm's canal. In one embodiment, a deployment mechanism within the delivery apparatus includes a push-pull type plunger. In some embodiments, the delivery applicator may be a guidewire, an expandable basket, an inflatable balloon, or the like.

#### Screw/Barb Anchored Stent

FIGS. 32 and 33 illustrate a glaucoma stent device 30f having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent 30f includes a barbed or threaded screw-like extension or pin 126 with barbs 128 for anchoring. The barbed pin 126 extends from a distal or base portion 130 of the stent 30f.

In use, the stent 30f (FIG. 32) is advanced through the trabecular meshwork 21 and across Schlemm's canal 22. The barbed (or threaded) extension 126 penetrates into the back wall 92 of Schlemm's canal 22 up to the shoulder or base 130 that then rests on the back wall 92 of the canal 22. The combination of a shoulder 130 and a barbed pin 126 of a particular length limits the penetration depth of the barbed pin 126 to a predetermined or preselected distance. In one embodiment, the length of the pin 126 is about 0.5 mm or less. Advantageously, this barbed configuration provides a secure anchoring of the stent 30f. As discussed above, correct, orientation of the stent 30f is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 32, the aqueous flows from the anterior chamber 20, through the lumen 42f, then out through two side-ports 56f to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56f. In other embodiments, more than two outlet ports 56f, for example,

six to eight ports (like a pin wheel configuration), may be efficaciously used, as needed or desired.

Still referring to FIG. 32, in one embodiment, the stent 30f is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30f may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Deeply Threaded Stent

FIG. 34 illustrates a glaucoma stent device 30g having features and advantages in accordance with one embodiment. The stent 30g has a head or seat 38g and a shank or main body portion 40g with a base or distal end 132. This embodiment of the trabecular stent 30g includes a deep thread 134 (with threads 136) on the main body 40g of the stent 30g below the head 38g. The threads may or may not extend all the way to the base 132.

In use, the stent 30g (FIG. 34) is advanced through the meshwork 21 through a rotating motion, as with a conventional screw. Advantageously, the deep threads 136 provide retention and stabilization of the stent 30g in the trabecular meshwork 21.

Referring to FIG. 34, the aqueous flows from the anterior chamber 20, through the lumen 42g, then out through two side-ports 56g to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56g. In other embodiments, more than two outlet ports 56g may be efficaciously used, as needed or desired.

One suitable applicator or delivery apparatus for this stent 30g (FIG. 34) includes a preset rotation, for example, via a wound torsion spring or the like. The rotation is initiated by a release trigger on the applicator. A final twist of the applicator by the surgeon and observation of suitable fiducial marks, indicia or the like ensure proper alignment of the side ports 56g with Schlemm's canal 22.

Referring to FIG. 34, in one embodiment, the stent 30g is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30g may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Rivet Style Stent

FIG. 35 illustrates a glaucoma stent device 30h having features and advantages in accordance with one embodiment. The stent has a base or distal end 138. This embodiment of the trabecular stent 30h has a pair of flexible ribs 140. In the unused state, the ribs are initially generally straight (that is, extend in the general direction of arrow 142).

Referring to FIG. 35, upon insertion of the stent 30h through the trabecular meshwork 21, the ends 144 of respective ribs 140 of the stent 30h come to rest on the back wall 92 of Schlemm's canal 22. Further advancement of the stent 30h causes the ribs 140 to deform to the bent shape as shown in the drawing of FIG. 35. The ribs 140 are designed to first buckle near the base 138 of the stent 30h. Then the buckling point moves up the ribs 140 as the shank part 40h of the stent 30h is further advanced through the trabecular meshwork 21.

The lumen 42h (FIG. 35) in the stent 30h is a simple straight hole. The aqueous flows from the anterior chamber 20, through the lumen 42h, then out around the ribs 140 to the collector channels further along Schlemm's canal 22 in either direction.

25

Referring to FIG. 35, in one embodiment, the stent 30*h* is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30*h* may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Grommet Style Stent

FIG. 36 illustrates a glaucoma stent device 30*i* having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent 30*i* includes a head or seat 38*i*, a tapered base portion 146 and an intermediate narrower waist portion or shank 40*i*.

In use, the stent 30*i* (FIG. 36) is advanced through the trabecular meshwork 21 and the base 146 is pushed into Schlemm's canal 22. The stent 30*i* is pushed slightly further, if necessary, until the meshwork 21 stretched by the tapered base 146 relaxes back and then contracts to engage the smaller diameter portion waist 40*i* of the stent 30*i*. Advantageously, the combination of the larger diameter head or seat 38*i* and base 146 of the stent 30*i* constrains undesirable stent movement. As discussed above, correct orientation of the stent 30*i* is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 36, the aqueous flows from the anterior chamber 20, through the lumen 42*i*, then out through two side-ports 56*i* to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56*i*. In other embodiments, more than two outlet ports 56*i* may be efficaciously used, as needed or desired.

Still referring to FIG. 36, in one embodiment, the stent 30*i* is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30*i* may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Biointeractive Stent

FIG. 37 illustrates a glaucoma stent device 30*j* having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent 30*j* utilizes a region of biointeractive material 148 that provides a site for the trabecular meshwork 21 to firmly grip the stent 30*j* by ingrowth of the tissue into the biointeractive material 148. As shown in FIG. 37, preferably the biointeractive layer 148 is applied to those surfaces of the stent 30*j* which would abut against or come in contact with the trabecular meshwork 21.

In one embodiment, the biointeractive layer 148 (FIG. 37) may be a region of enhanced porosity with a growth promoting chemical. In one embodiment, a type of bio-glue 150 that dissolves over time is used to hold the stent secure during the time between insertion and sufficient ingrowth for stabilization. As discussed above, correct orientation of the stent 30*j* is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 37, the aqueous flows from the anterior chamber 20, through the lumen 42*j*, then out through two side-ports 56*j* to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56*j*. In other embodiments, more than two outlet ports 56*j* may be efficaciously used, as needed or desired.

26

Still referring to FIG. 37, in one embodiment, the stent 30*j* is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30*j* may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Glued or Welded Stent

FIG. 38 illustrates a glaucoma stent device 30*k* having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent 30*k* is secured in place by using a permanent (non-dissolving) bio-glue 152 or a "welding" process (e.g. heat) to form a weld 152. The stent 30*k* has a head or seat 38*k* and a lower surface 46*k*.

The stent 30*k* is advanced through the trabecular meshwork 21 until the head or seat 38*k* comes to rest on the trabecular meshwork 21, that is, the head lower surface 46*k* abuts against the trabecular meshwork 21, and the glue or weld 152 is applied or formed therebetween, as shown in FIG. 38. As discussed above, correct orientation of the stent 30*k* is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 38, the aqueous flows from the anterior chamber 20, through the lumen 42*k*, then out through two side-ports 56*k* to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56*k*. In other embodiments, more than two outlet ports 56*k* may be efficaciously used, as needed or desired.

Still referring to FIG. 38, in one embodiment, the stent 30*k* is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30*k* may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

#### Hydrophilic Latching Stent

FIG. 39 illustrates a glaucoma stent device 30*m* having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent 30*m* is fabricated from a hydrophilic material that expands with absorption of water. Desirably, this would enable the device 30*m* to be inserted through a smaller incision in the trabecular meshwork 21. The subsequent expansion (illustrated by the smaller arrows 154) of the stent 30*m* would advantageously enable it to latch in place in the trabecular meshwork 21. As discussed above, correct orientation of the stent 30*m* is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 39, the aqueous flows from the anterior chamber 20, through the lumen 42*m*, then out through two side-ports 56*m* to be directed in both directions along Schlemm's canal 22. Alternatively, flow could be directed in only one direction through a single side-port 56*m*. In other embodiments, more than two outlet ports 56*m* may be efficaciously used, as needed or desired.

Still referring to FIG. 39, in one embodiment, the stent 30*m* is inserted through a previously made incision in the trabecular meshwork 21. In other embodiments, the stent 30*m* may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork 21 is made by the self-trephining stent device which has a blade at its base or proximate to the base.

## Photodynamic Stent

FIG. 40 illustrates a glaucoma stent device **30n** having features and advantages in accordance with one embodiment. This embodiment of the trabecular stent **30n** is fabricated from a photodynamic material that expands on exposure to light.

It is commonly known that there is a diurnal variation in the aqueous humor production by the eye—it is higher during the day than it is at night. The lumen **42n** of the stent **30n** responds to light entering the cornea during the day by expanding and allowing higher flow of aqueous through the lumen **42n** and into Schlemm's canal **22**. This expansion is generally indicated by the smaller arrows **156** (FIG. 40) which show the lumen **42n** (and ports) expanding or opening in response to light stimulus. (The light or radiation energy  $E$  is generally given by  $E=h\nu$ , where  $h$  is Planck's constant and  $\nu$  is the frequency of the light provided.) At night, in darkness, the lumen diameter decreases and reduces the flow allowed through the lumen **42n**. In one embodiment, an excitation wavelength that is different from that commonly encountered is provided on an as-needed basis to provide higher flow of aqueous to Schlemm's canal **22**.

This photodynamic implementation is shown in FIG. 40 for the self-latching style of stent **30n**, but can be efficaciously used with any of the other stent embodiments, as needed or desired. As discussed above, correct orientation of the stent **30n** is ensured by appropriate fiducial marks, indicia or the like and by positioning of the stent in a preloaded applicator.

Referring to FIG. 40, the aqueous flows from the anterior chamber **20**, through the lumen **42n**, then out through two side-ports **56n** to be directed in both directions along Schlemm's canal **22**. Alternatively, flow could be directed in only one direction through a single side-port **56n**. In other embodiments, more than two outlet ports **56n** may be efficaciously used, as needed or desired.

Still referring to FIG. 40, in one embodiment, the stent **30n** is inserted through a previously made incision in the trabecular meshwork **21**. In other embodiments, the stent **30n** may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork **21** is made by the self-trephining stent device which has a blade at its base or proximate to the base.

## Collector Channel Alignment Stent

FIG. 41 illustrates a glaucoma stent device **30p** having features and advantages in accordance with one embodiment. This figure depicts an embodiment of a stent **30p** that directs aqueous from the anterior chamber **20** directly into a collector channel **29** which empties into aqueous veins. The stent **30p** has a base or distal end **160**.

In the illustrated embodiment of FIG. 41, a removable alignment pin **158** is utilized to align the stent lumen **42p** with the collector channel **29**. In use, the pin **158** extends through the stent lumen **42p** and protrudes through the base **160** and extends into the collector channel **29** to center and/or align the stent **30p** over the collector channel **29**. The stent **30p** is then pressed firmly against the back wall **92** of Schlemm's canal **22**. A permanent bio-glue **162** is used between the stent base and the back wall **92** of Schlemm's canal **22** to seat and securely hold the stent **30p** in place. Once positioned, the pin **158** is withdrawn from the lumen **42p** to allow the aqueous to flow directly from the anterior chamber **20** into the collector duct **29**. The collector ducts are nominally 20 to 100 micrometers ( $\mu\text{m}$ ) in diameter and are visualized with a suitable microscopy method (such as ultrasound biomicroscopy (UBM)) or laser imaging to provide guidance for placement of the stent **30p**.

Referring to FIG. 41, in one embodiment, the stent **30p** is inserted through a previously made incision in the trabecular meshwork **21**. In other embodiments, the stent **30p** may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork **21** is made by the self-trephining stent device which has a blade at its base or proximate to the base.

## Barbed Stent (Anterior Chamber to Collector Channel)

FIG. 42 illustrates a glaucoma stent device **30q** having features and advantages in accordance with one embodiment. This figure depicts an embodiment of a stent **30q** that directs aqueous from the anterior chamber **20** directly into a collector channel **29** which empties into aqueous veins. The stent **30q** has a base or distal end **166** and the channel **29** has wall(s) **164**.

In the illustrated embodiment of FIG. 42, a barbed, small-diameter extension or pin **168** on the stent base **166** is guided into the collector channel **29** and anchors on the wall(s) **164** of the channel **29**. The pin **168** has barbs **170** which advantageously provide anchoring of the stent **30q**. The collector ducts **29** are nominally 20 to 100 micrometers ( $\mu\text{m}$ ) in diameter and are visualized with a suitable microscopy method (such as ultrasound biomicroscopy (UBM)) or laser imaging to provide guidance for placement of the stent.

Referring to FIG. 42, in one embodiment, the stent **30q** is inserted through a previously made incision in the trabecular meshwork **21**. In other embodiments, the stent **30q** may be combined with any of the blade configurations taught or suggested herein to provide self-trephining capability. In these cases, the incision through the trabecular meshwork **21** is made by the self-trephining stent device which has a blade at its base or proximate to the base.

## Valved Tube Stent (Anterior Chamber to Choroid)

FIG. 43 illustrates a valved tube stent device **30r** having features and advantages in accordance with one embodiment. This is an embodiment of a stent **30r** that provides a channel for flow between the anterior chamber **20** and the highly vascular choroid **17**. Clinically, the choroid **17** can be at pressures lower than those desired for the eye **10**. Therefore, this stent **30r** includes a valve with an opening pressure equal to the desired pressure difference between the choroid **17** and the anterior chamber **10** or a constriction that provide the desired pressure drop.

## Osmotic Membrane (Anterior Chamber to Choroid)

FIG. 44 illustrates an osmotic membrane device **30s** having features and advantages in accordance with one embodiment. This embodiment provides a channel for flow between the anterior chamber **20** and the highly vascular choroid **17**. The osmotic membrane **30s** is used to replace a portion of the endothelial layer of the choroid **17**. Since the choroid **17** is highly vascular with blood vessels, the concentration of water on the choroid side is lower than in the anterior chamber **20** of the eye **10**. Therefore, the osmotic gradient drives water from the anterior chamber **20** into the choroid **17**.

Clinically, the choroid **17** (FIG. 44) can be at pressures lower than those desired for the eye **10**. Therefore, desirably, both osmotic pressure and the physical pressure gradient are in favor of flow into the choroid **17**. Flow control is provided by proper sizing of the area of the membrane, the larger the membrane area is the larger the flow rate will be. This advantageously enables tailoring to tune the flow to the desired physiological rates.

## Ab Externo Insertion of Stent Via Small Puncture

FIG. 45 illustrates the implantation of a stent **30t** using an ab externo procedure having features and advantages in accordance with one embodiment. In the ab externo procedure

29

ture of FIG. 45, the stent 30*t* is inserted into Schlemm's canal 21 with the aid of an applicator or delivery apparatus 100*c* that creates a small puncture into the eye 10 from outside.

Referring to FIG. 45, the stent 30*t* is housed in the applicator 100*c*, and pushed out of the applicator 100*c* once the applicator tip is in position within the trabecular meshwork 21. Since the tissue surrounding the trabecular meshwork 21 is optically opaque, an imaging technique, such as ultrasound biomicroscopy (UBM) or a laser imaging technique, is utilized. The imaging provides guidance for the insertion of the applicator tip and the deployment of the stent 30*t*. This technique can be used with a large variety of stent embodiments with slight modifications since the trabecular meshwork 21 is punctured from the scleral side rather than the anterior chamber side in the ab externo insertion.

#### Ab Externo Grommet-Style Stent

FIG. 46 illustrates a glaucoma stent device 30*u* having features and advantages in accordance with a modified embodiment. This grommet-style stent 30*u* for ab externo insertion is a modification of the embodiment of FIG. 36. In the embodiment of FIG. 46, the upper part or head 38*u* is tapered while the lower part or base 172 is flat, as opposed to the embodiment of FIG. 36. The stent 30*u* is inserted from the outside of the eye 10 through a puncture in the sclera. Many of the other embodiments of stents taught or suggested herein can be modified for similar implantation.

This ultra microscopic device 30*u* (FIG. 46) can be used with (1) a targeting Lasik-type laser, with (2) contact on eyes, with (3) combined ultrasound microscope, or with (4) other device inserter handpiece.

#### Targeted Drug Delivery to the Trabecular Meshwork

FIG. 47 illustrates a targeted drug delivery implant 30*v* having features and advantages in accordance with one embodiment. This drawing is a depiction of a targeted drug delivery concept. The slow release implant 30*v* is implanted within the trabecular meshwork 21.

A drug that is designed to target the trabecular meshwork 21 to increase its porosity, or improve the active transport across the endothelial layer of Schlemm's canal 22 can be stored in this small implant 30*v* (FIG. 47). Advantageously, slow release of the drug promotes the desired physiology at minimal dosage levels since the drug is released into the very structure that it is designed to modify.

#### Dose Response

The programmed (also know as "Targeted") stent placement refers to the intentional placement of a stent or stents at a particular location or locations in Schlemm's canal for the purpose of providing a benefit in the form of more optimal outflow. For example, a method can be provided which includes assessing the aqueous flow characteristics of an eye. Such characteristics can include, for example, but without limitation, collector channel distribution, collector channel flow characteristics, outflow resistance, outflow capacity, shape/size/tortuosity of Schlemm's canal, and other factors). The method can also include determining an optimal stent placement and implanting stents in one or plurality of positions and procedures. For example, the determination of the desired stent placement can include consideration of a database of cadaver anatomy regarding the number and location of collector channels, the patient's micro-anatomy data, the number of stents to be used, the type of stents to be used, the location of any previously implanted stents whether the desired stent is drug-loaded, gene-loaded or surface treated, and/or any associated drug therapy.

FIG. 48 includes a flow diagram illustrating a decision tree for determining desired stent placement. In the illustrated embodiment, after it is determined that a patient is suffering

30

from excess of intraocular pressure (IOP), a bypass flow model is determined to aid in the decision of whether or not to use single or multiple stents. Optionally, the configuration of collector channels in the patient's eye can be met to aid in the creation of a bypass flow model. Further, other information can be used, such as, for example, but without limitation, outflow resistance, aqueous production, and venous pressure.

The bypass flow model, which can be based on the above-noted information, is determined so as to provide a desired strategy for lowering the excessive intraocular pressure. If it is decided that a single stent should be used, an optimized stent location is first determined based on the bypass flow model. The implantation of the single stent results in reduced IOP. After this implantation, it is again determined if there is a need for further reduction in IOP. If additional IOP reduction is desired, then a further bypass flow model is created. For example, the second bypass flow model can be determined in the same or similar manner as the first bypass flow model described above. In light of the second bypass flow model, an additional stent can be implanted at an optimized location to further reduce IOP.

If it is determined, in light of the first bypass flow model, that multiple stents should be used, the location of the multiple stents is first optimized. Then, the multiple stents are implanted. Afterwards, it is again determined if additional intraocular pressure reduction is needed, and the trimming can continue as noted above.

#### Multiple Stent Application and Further Stent Designs

Where additional stents are implanted in light of the second bypass flow model, the additional stents can be different from the first stents implanted. For example, where single or multiple stents are implanted in accordance with the first bypass flow model, the additional stents can be of a different type. For example, in one embodiment, the first stent is a G1 (First generation) trabecular stent that has been disclosed in applications incorporated by reference and the second stent is the same G1 trabecular stent. In another embodiment, the second stent is different from the first stent; for example, the second stent is a G2 stent (that is, "injectable axisymmetric stent," a second generation stent). In still another embodiment, the second stent is smaller than (in some case, larger than) the first stent. The dose response may also relate to the stent configuration or characteristics such as drug-loading or surface treatment enabling enhancing aqueous transport or therapeutic effects on the tissue as needed. Drug-loaded or drug-eluting stent may comprise different type of drugs including, but not limited to, those cited in U.S. patent application Ser. No. 10/046,137 filed Nov. 8, 2001, entitled DRUG RELEASING TRABECULAR IMPLANT FOR GLAUCOMA TREATMENT.

With reference to FIG. 49A, a stent extending between an anterior chamber 20 of an eye, through the trabecular meshwork 21, and into Schlemm's canal 22 of an eye can be configured to be axisymmetric with respect to the flow of aqueous therethrough. For example, as shown in FIG. 49A, the stent 229A comprises an inlet end 230 configured to be disposed in the anterior chamber 20. The second end 231 of the stent 229A is configured to be disposed in Schlemm's canal 22.

At least one lumen 239 extends through the stent 229A between the inlet and outlet ends 230, 232. The lumen 239 defines an opening 232 at the inlet end 230 as well as an outlet 233 at the outlet end 231.

In the illustrated embodiment, an exterior surface 238 of the stent 229A is cone-shaped. Thus, a circumference of the



31

exterior surface 238 adjacent to the inlet end 230 is smaller than the circumference of the outer surface 238 at the outlet end 231.

With the stent 229A extending through the trabecular meshwork 21, the tissue of the trabecular meshwork 221 provides additional anchoring force for retaining the stent 229A with its inlet end 230 in the anterior chamber and its outlet end 231 in Schlemm's canal. For example, the trabecular meshwork 21 would naturally tend to close an aperture occupied by the stent 229A. As such, the trabecular meshwork 221 would tend to squeeze the stent 229A. Because the exterior surface 238 is conical, the squeezing force applied by the trabecular meshwork 221 would tend to draw the stent 229A towards Schlemm's canal 22. In the illustrated embodiment, the stent 229A is sized such that a portion 234 of the stent 229 adjacent to the inlet end 230 remains in the anterior chamber 20 while a portion 235 of the stent 229 adjacent to the outlet end 231 remains in Schlemm's canal 22.

In the illustrated embodiment, the outer surface 238 of the stent 229A is straight. Alternatively, the outer surface 238 can have other contours such as, for example, but without limitation curved or stepped. In one embodiment, the outer surface 238 can be curved in a concave manner so as to produce a trumpet-like shape. Alternatively, the outer surface 238 can be convex.

The stent 229A preferably includes one or plurality of posts or legs 236 configured to maintain a space between the outlet opening 233 and a wall of Schlemm's canal 22. As such, the legs 236 prevent a wall of Schlemm's canal from completely closing off the outlet opening 233 of the stent 229A. In the illustrated embodiment, the legs 236 are coupled to the distal-most surface of the stent 229A and are substantially parallel to an implant axis extending through the stent 229A and between the anterior chamber 20 and Schlemm's canal 22.

This arrangement of the legs 236 and the outlet 233 imparts an axisymmetric flow characteristic to the stent 229A. For example, aqueous can flow from the outlet 233 in any direction. Thus, the stent 229A can be implanted into Schlemm's canal at any angular position relative to its implant axis. Thus, it is not necessary to determine the angular orientation of the stent 229A prior to implantation, nor is it necessary to preserve a particular orientation during an implantation procedure.

FIG. 49B illustrates a modification of the stent 229A, identified generally by the reference numeral 229B. In this embodiment, the stent 229B includes a flange 237 extending radially from the portion 234. Preferably, the flange 237 is configured to retain the first portion 234 within the anterior chamber 20. It is to be recognized that although generally, aqueous will flow from the anterior chamber 20 towards Schlemm's canal 22, the stent 229A, 229B or any of the above-described stents as well as other stents described below, can provide for omni-directional flow of aqueous.

FIG. 49C illustrates another modification of the stent 229A, identified generally by the reference numeral 229C. In this embodiment, the outer surface 238C is not conical. Rather, the outer surface 238C is cylindrical. The stent 229C includes a flange 240 that can be the same size and shape as the flange 237. The legs 236C extend from the flange 240.

Constructed as such, the natural tendency of the tissue of the trabecular meshwork 21 to close the hole in which the stent 229C is disposed, aids in anchoring the stent 229C in place. Additionally, the legs 236C aid in preventing the walls of Schlemm's canal from completely closing the outlet 233C of the lumen 239C.

32

Device for Mechanically Distending Collector Duct

FIG. 50A is an enlarged cross-sectional view of a portion of the eye 10 showing, anatomically, the trabecular meshwork 21, Schlemm's canal 22, and a collector duct 23 in a natural state. FIG. 50B shows a stent 229C extending into and thereby distending the collector duct 23.

The collector duct 23 has an inner diameter identified generally by the reference numeral D1, when in a relaxed or natural state. Because the collector duct 23 is not typically perfectly round, the diameter D1 can correspond to an "equivalent" diameter. As used herein, the equivalent diameter can be determined by dividing the circumference of the inner surface of the collector duct 23 by  $\pi$ .

The stent 229D is sized to extend from the anterior chamber 20 and into the collector duct 23. Thus, in the illustrated embodiment, the stent 229D includes an upstream end portion 230D and a downstream end portion 243.

The upstream portion 230D is configured to open into the anterior chamber 20. The stent 229D is sized so as to extend from the anterior chamber 20 and into the collector duct 23. In the illustrated embodiment, the stent 229D is sized so as to extend from the anterior chamber 20, through the trabecular meshwork 21, through a portion of Schlemm's canal 22, and into the collector duct 23. However, it is conceived that the stent 229D could bypass Schlemm's canal 22 and extend directly into a portion of the collector duct 23 downstream from Schlemm's canal 22.

The downstream end portion 243 can have an outer diameter D2 that is larger than the diameter D1. Preferably, the end portion 243 is sized and configured for easy insertion into a collector duct 23 without injuring the tissue or tissue surface of the collector duct 23. Thus, when the end portion 243 is disposed in the collector duct 23, the collector duct 23 is distended, i.e., enlarged. As such, the resistance against the outflow of aqueous provided by the collector duct 23 in its natural state can be reduced, thereby reducing IOP.

Preferably, the end portion 243 has a diameter D2 substantially larger than the equivalent diameter D1 of the duct 23 so as to deform the collector duct beyond its elastic threshold into plastic deformation region. As such, the collector duct 23 can aid in anchoring the stent 229D in place.

Applicator for Multiple Stent Implantation and Further Stents

FIG. 51A is a perspective view of a stent delivery applicator 201 configured for multiple stent deployment. The delivery applicator 201 comprises an injection sheath 246 defining a stent lumen 249, a distal stent-holding section 259, and a handle 205.

The handle 205 includes an outer surface preferably configured to be grasped by a human hand. Additionally, the handle can comprise a stent delivery button 203. By way of example, the stent delivery button 203 is configured to cause a stent discharge mechanism to discharge, from the applicator sheath 246, one stent at a time. The applicator 201 can be configured to store and discharge a plurality of any combination of the stents 229, 30, 30a, 30b, 30c, 30d, 30e, 30f, 30g, 30h, 30i, 30j, 30k, 30m, 30n, 30p, 30q, 30r, 30s, 30t, 30u, 30v, 229A, 229B, 229C, and 229D described above and further embodiments and combinations thereof described hereafter, the additional stents described below, or any other ocular stent or implant. In the illustrated embodiment, the applicator 201 is loaded with a plurality of the stents 229C.

The applicator 201 can include other features as well, for example, but without limitation, an optional connector 209 for connecting to an external ultrasound power source, a fluid infusing port 204 for fluid infusion or viscocanalostomy, and a steering mechanism control device 202 configured to control the steering of a steerable section 251 of the applicator 201.

The steerable section **251** can be configured to deflect the distal stent-holding section **259** about at least one axis. Optionally, the steerable section **251** can be configured to deflect the distal stent-holding section **259** about at least two axes, one axis being substantially perpendicular to the other. Thus, the portion of the sheath **246** which defines part of the steerable section **251** is flexible. Generally, similar steering mechanisms for deflecting a portion of an medical device, such as endoscopes, are well-known in the art.

With reference to FIG. **51B**, in the illustrated embodiment, the steering actuator **202** is connected to a plurality of pulling wires **256A**, **256B**. The wires **256A**, **256B** have distal portions **253A**, **253B**, respectively, disposed distally from the handle **205**. The end **252A** of the distal wire portion **253A** of the first pulling wire **256A** is attached to one side of an inner surface of the sheath **246**. The second pulling wire **256B** has its end **252B** of the distal wire portion **253B** attached to the opposite side of the inner surface of the sheath **246**. The wire ends **252A** and **252B** are disposed within the steerable distal section **251**.

With reference to FIG. **51C**, a relatively rigid guide **254** is disposed in the lumen at an appropriate location proximal to the wire ends **252A**, **252B**. The guide is configured to guide the pull wires **256A**, **256B** such that the sheath **246** is deflected when the pull wires **256A**, **256B** are pulled. In the illustrated embodiment, the guide **254** is in the form of a plate member.

The guide **254** can include holes **255A**, **255B** through which the pulling wires **253A**, **253B** extend. The guide **254** and the points at which the wire ends **252A**, **252B** are spaced. As such, when the pull wires **253A**, **253B** are pulled by actuation of the steering actuator **202**, the distal end of the sheath **246** is deflected. For example, as shown in FIG. **51D**, when the wire **256A** is pulled, the sheath deflects from Position I to Position II.

As noted above, the delivery apparatus **201** can be configured to discharge a plurality of stents, one at a time, for implantation. In the illustrated embodiment, as shown in FIG. **51B**, the delivery apparatus **201** includes a plunger **244** connected with the stent delivery button **203**. The plunger **244** can comprise one or a plurality of plunger bodies that are joined at the distal plunger end **244B**. The distal plunger end **244B** has a generally round configuration and smooth surface adapted for evenly pushing a stent, such as the stent **229C**, out of the sheath during a deployment phase of an implantation procedure.

As noted above, the sheath **246** defines a lumen **249** having a plunger **244**. A space between the plunger **244** and the distal end **242** is reserved for storing a plurality of stents. The sheath **246** includes at least one holding member **245** for each stent **229C** stored therein. The holding members **245** are configured to retain the stents **229C** in place during storage and use, and to allow the stents **229C** to pass when the stent **229C** is pushed by the plunger **244**.

In the illustrated embodiment, the sheath **146** includes a row of a plurality of holding members **245** upstream and downstream from each stent **229C** stored in the sheath **246**. Thus, each stent **229C** is prevented from unintentionally moving in the upstream and downstream directions.

FIG. **51B** illustrates two stents **229C** being stored in the sheath **246**. However, it is conceived that the sheath **246** and holding members **245** can be configured to hold one, three, or more stents **229C** within the stent-holding distal end **259**.

The holding member **245** can be a wire configured to exerted a force to hold the stents **229C** in place during storage and use, until the plunger **244** is moved to discharge a stent **229C** from the end **242**. For example, the wire can be made

from a spring metal, an elastically deformable plastic, or other material, sized and shaped to retain the stents **229C** during storage, and to allow the stents **229C** to pass under a force that can be generated by or applied to the plunger **244**, toward the end **242**. In the illustrated embodiment, the wires forming the holding members **245** extend generally parallel to and convexly into the lumen **249**, and thus define stops for preventing unintentional movement of the stents **229C**.

Alternatively, the holding members **245** can be in the form of a mechanically or electronically actuable gate. Such a gate can be configured to move from a closed position in which the stents **229C** are retained in the storage positions, and an open position in which the stents **229C** can be moved in the downstream direction. A mechanical gate can be formed from members that can be moved or deflected radially from the inner surface of the lumen **249**, under the control of a pull wire (not shown). An electronic gate can also include radially moveable or deflectable members controlled by an electronic actuator, such as, for example, but without limitation, solenoids, stepper motors, servo motors, and piezoelectric modules.

Alternatively, piezoelectric modules can be used to form the holding members. For example, small piezoelectric modules can be mounted on the inner surface of the sheath **246** to form stops when in a locked position. The piezoelectric modules can be connected to a power supply with conduits. Thus, when actuated, the piezoelectric modules can contract so as to move to an open position in which the stents **229C** can pass.

As noted above, the applicator **201** preferably is configured to eject one stent at a time from the end **242**. Thus, the applicator **201** can be configured to move the plunger **244** a predetermined distance each time the button **203** is depressed. For example, the button can be mechanically connected to the plunger **244** so as to move the plunger **244** downstream through the sheath **246** over the predetermined distance. The predetermined distance can be, for example, equal to about the length of the stent **229C**.

Alternatively, the plunger can be driven by an electronic actuator (not shown) configured to eject one stent **229C** at a time from the sheath **246**. For example, the electronic actuator can be configured to drive the plunger **244** over the predetermined distance each time the button **203** is depressed. The electronic actuator can be, for example but without limitation, solenoids, stepper motors, servo motors, and piezoelectric modules. Driver electronics (not shown) can be configured to drive the actuator so as to urge the plunger **244** over the predetermined distance.

Preferably, the end **242** of the sheath **246** is sharpened to define a cutting (microtrephining) tip for creating a hole within the trabecular meshwork **21** for stent placement. Thus, the applicator **201** can be used for cutting the trabecular meshwork **21** and for implanting stents.

A further advantage is provided where the applicator includes an illumination feature for illuminating at least a portion of the implantation site. For example, the illumination feature can be configured to generally illuminate the site at which a stent is to be implanted. Optionally, the illumination feature can be configured to generate a reticule for aligning the applicator with the desired implantation site. In one embodiment, a light source is provided to the tip section **242** of the stent applicator **201** wherein either laser light is provided for cutting/spotting or fiber optic light is provided for illumination.

For example, but without limitation, the illumination feature can comprise a small diameter light pipe or optic fiber element configured to emit a fine point or beam of light and configured to be introduced ab-internally. Additionally, the

35

face or lens of the pipe or element can be configured to be placed against the trabecular meshwork. In one embodiment, the light pipe or optic fiber is the construct material of the sheath **246** of the stent delivery applicator **241A** for multiple stent deployment as shown in FIG. **51B**. In another embodiment, the light pipe or optic fiber is snugly inserted within the lumen **249** of the applicator sheath **246** or over the outer periphery of the applicator sheath **246**. Optionally, the illumination device can be configured such that the point or beam emitting from the light tube would be highly visible from the outside of the eye and serve to guide the implantation of a stent.

As an alternative to including an illumination feature with the applicator **201**, simple non-invasive trans-scleral illumination, if of the proper intensity and wavelength, perhaps in a darkened environment, could silhouette the Schlemm's canal, trabecular meshwork, or more probably, the scleral spur with sufficient resolution to enable ab-externo placement of a device into Schlemm's canal. In this case, blood could be backed up in a retrograde manner into Schlemm's canal by the surgeon to provide additional optical density. Imaging means for ab internally imaging the anatomic structures for TBS stent implantation using ultrasound imaging, laser imaging, OCT imaging or multi-wavelength scanning can also be provided.

A further advantage is provided where the applicator **201** also includes an imaging feature. For example, where the applicator **201** includes an imaging feature for transmitting a video representation of an implantation site of a stent to a user of the applicator, an implantation procedure can be further simplified. The imaging feature can utilize any type of known imaging techniques, including, for example, but without limitation, optical, and ultrasonic. In one embodiment, an endoscope is mounted at the tip section **242** of the stent applicator **201** for visualization during stent deployment and/or implantation.

FIG. **51D** shows one embodiment of the applicator **201** of FIG. **51A** having an ultrasonic imaging system. The illustrated embodiment of the imaging system is included on an applicator with a steerable section. However, it is to be noted that the imaging system can be used on an applicator that does not have a steerable section.

In one embodiment, the ultrasonic imaging system comprises two ultrasonic probes or transducers **206**, **207**. The transducers **206**, **207** can be formed from an ultrasound ring or ultrasound tape. Preferably, the transducers **206**, **207** are located adjacent to the distal end **242** of the delivery apparatus **201**. As such, the transducers **206**, **207** can move with the distal end **242** during an implantation procedure.

The ultrasonic transducers **206**, **207** are connected by flexible wires (not shown) through the interior void **243** of the apparatus or through within the sheath **246** to the connector **209** located at the handle **205** so that the ultrasonic signals are directed outwardly and received inwardly relative to the transducers **206**, **207**. For example, one of the transducers **206**, **207** can be configured to emit ultrasonic energy, and the other can be configured to absorb the reflected portion of the emitted ultrasonic energy and to produce a signal indicative of the absorbed energy.

In order to enhance the viewing and positioning of the distal end **242** of the apparatus, an ultrasonic marker **208**, which is visible to ultrasonic energy, can be mounted at about the distal end **242** of the applicator **201**. For example, but without limitation, such a marker **208** can be in the form of one or a plurality of encapsulated air bubbles. In one illustrative example, the bubble in a marker **208** can be formed by

36

introducing air by a syringe (not shown) penetrating the wall of the sheath **246** and thereafter sealing the hole created by the syringe with epoxy.

Optionally, a plurality of markers **208** can be disposed in the front distal section **259**. The markers **208** can be sized and configured to aid in locating and identifying the orientation of the distal end section **259**. For example, the markers **208** can be located and/or viewed with external ultrasonic imaging systems (not shown), such as those commonly used in similar medical procedures.

A further advantage is provided where the stent delivery applicator **201** is both steerable and configured for multiple stent implantation. As such, the applicator **201** can be inserted into the anterior chamber **20**, through an incision, such as a corneal incision, and multiple stents can then be implanted at different locations without removing the applicator **201** or creating other incisions, described in greater detail below.

FIG. **52A** shows another embodiment of the stent delivery distal portion **241**, identified generally by the reference numeral **241B**, and another embodiment of a stent, identified generally by the reference numeral **229E**.

The stent **229E** comprises a first (proximal) flange **240E** and a second (distal) flange **237E** with a plurality of supporting legs or posts **236**. The second flange **237E** of the stent **229E** is configured to be foldable. For example, the first flange **237E** can be configured to be elastically foldable toward an upstream direction. As such, the first flange **237E** can be folded toward an upstream direction, as illustrated in FIG. **52A** when stored in the sheath **246**. Thus, after the first flange **237E** has been pushed through the end **242**, the first flange **237E** can resiliently unfold. As such, the first flange **237E** can provide enhanced anchoring for the stent **229E** when implanted into the trabecular meshwork **21**.

A further advantage can be provided where the applicator **201** includes a cutting device that can extend through the lumens **239E** of the stents **229E**. For example, as shown in FIG. **52A**, a cutting device **250** can include a cutting tip **247** and can be configured to extend through the stents **229E** during an implantation procedure. As such, the cutting device can be an incision at the center of the site at which the stent **229E** is to be inserted through the trabecular meshwork **21**. In the illustrated embodiment, the cutting device is in the form of a trocar.

With continued reference to FIG. **52A**, the cutting device **250** is configured to be moveable axially through the lumen **249** of the applicator end portion **241B** of the sheath **146**. Additionally, the cutting device **250** can be moved axially relative to the stent or stents through which it extends.

Another advantage can be provided where the cutting device **250** also includes at least one holding member for holding a stent. For example, the cutting device **250** includes at least one holding device **245**, described above with reference to FIG. **51B**, can be configured to hold a stent at least during an implantation procedure, and to release the stent at the appropriate time.

Preferably, the holding members **245B** are arranged to align the sides of the cutting tip **247** with the distally facing sides of the flange **237E** when the flange **237E** is folded. For example, as shown in FIG. **52A**, when the flange **237E** is folded, the distally facing side of the flange **237E** is aligned with the sides of the cutting tip **247**, as indicated by the dashed-lines identified by the letter "A." This alignment can be facilitated by arranging the holding members **245B** such that the cutting device **250** extends distally from the flange **237E** sufficiently to cause the sides of the cutting tip **247** to become aligned with the flange **237E**. As such, the sides of the cutting tip **247** and the distally facing side of the flange **237E**

37

generate a more smooth surface for penetrating the trabecular meshwork **21** during an implantation procedure.

During operation, the applicator end portion **241B** can be pushed into trabecular meshwork **21**, with the flange **237E** disposed in Schlemm's canal **22**, as shown in FIG. **52B**. The sheath **246** can then be retracted out of Schlemm's canal **22**, leaving the cutting device **250** and stent **229E** in place (FIG. **52C**).

With the sheath **246** retracted, the first flange **237E** can unfold, as indicated by the arrows **U** in FIG. **52C**, thereby providing enhanced anchoring of the stent **229E** within Schlemm's canal **22** (FIG. **52D**). Additionally, the second flange **240E** is within the anterior chamber **20**.

As shown in FIG. **52D**, the cutting device **250** can then be retracted relative to the applicator end portion **241B** and the stent **229E**, leaving the stent **229E** in place. Optionally, the cutting device **250** and the sheath **246** can be retracted together.

As noted above, the holding members **245** are configured to limit the movement of the stents **229E** relative to the cutting device **250**. When the cutting device is retracted, the next stent **229E** preferably is moved passed (in the downstream direction) the holding member **245** that was previously between the stents **229E**. As such, the next stent **229E** can be moved into position for implantation. Thus, the holding members **245** preferably are configured to allow the stent **229E** to move toward the cutting tip **247** when the cutting device **250** is retracted. For example, the holding members **245** can be controlled so as to retract when the cutting device **250** is retracted.

With reference to FIG. **53**, another embodiment of an axisymmetric trabecular stenting device is illustrated therein and identified generally by the reference numeral **229F**. For ease of description, but without limitation, the stent **229F** is described below with reference to cylindrical coordinates of  $x$ ,  $r$  and angle  $\alpha$  as shown in FIG. **53**.

The stent **229F** comprises an inlet (proximal) section having a first flange **240F**, an outlet (distal) section having a second flange **237F** and a middle section **284** connecting the inlet section and the outlet section. A lumen **239F** of the device **229F** is configured to transport aqueous, liquid, or therapeutic agents between the inlet section and the outlet section. As referred to herein, "therapeutic agent" is intended to include pharmaceutical agents, drugs, genes, cells, proteins, and/or growth factors.

The inlet section of the stent **229F** has at least one inlet opening **286** and the outlet section comprises at least one outlet opening **287**. A further advantage is provided where the outlet section **237F** includes at least one opening **287**, **288** suitably located for discharging substantially axisymmetrically the aqueous, liquid or therapeutic agents, wherein the opening **287**, **288** is in fluid communication with the lumen **285** of the device **281**. In the illustrated embodiment, the openings **288** extend radially from the lumen **285** and open at the outwardly facing surface around the periphery of the outlet flange **237F**.

In one embodiment of an implantation procedure, Pilocarpine is administered preoperatively to constrict the pupil to provide maximal protection of the lens in phakic individuals and to further open the anterior chamber angle to provide a better view of the surgical site. Topical and retrobulbar anesthetic are recommended. A small self-sealing temporal corneal incision can be made and HEALON® viscoelastic (VE) can be injected to maintain the anterior chamber.

A microscope can be tilted slightly toward the surgeon and the patient's head can be rotated away from the surgeon to provide a suitable view of the nasal trabecular meshwork

38

using a direct-view gonioscope that is placed on the eye. The applicator **201** with a preloaded stent, such as, for example, but without limitation, an one or any combination of the stents a plurality of any combination of the stents **229**, **30**, **30a**, **30b**, **30c**, **30d**, **30e**, **30f**, **30g**, **30h**, **30i**, **30j**, **30k**, **30m**, **30n**, **30p**, **30q**, **30r**, **30s**, **30t**, **30u**, **30v**, **229A**, **229B**, **229C**, **229D**, **229E**, **229F**, or any of the other stents described below, is advanced through the corneal wound and across the anterior chamber. The stent is pushed against the trabecular meshwork and moved inferiorly to pierce the trabecular meshwork and guide the stent into Schlemm's canal. After successful implantation and release of the stent, the applicator is withdrawn and the VE is flushed from the eye.

The G2 stent (for example, stent **229F** of FIG. **53**) can be smaller and of a significantly different design than the G1 stents, thus allowing it to be passed through a smaller corneal incision and be implanted with a simple axial motion. Reduced size and simplified surgical motions may enable implantation of the G2 stent without the use of viscoelastic and therefore eliminate a significant expendable material cost and the time necessary to administer and remove it.

Additionally, viscoelastic use in patients undergoing eye surgery can cause post-operative transient IOP spikes that can further damage the remaining glaucoma-compromised retina. Reduced surgical manipulations reduce the burden on the surgeon and reduce the stimulation and irritation of intraocular tissues. Furthermore, reduction in the corneal incision size raises the possibility that the incision could be made by the G2 applicator, and could potentially reduce the surgical implant procedure to an injectable implant procedure. Injectable stent therapy represents a potentially superior alternative to both end-stage, surgical therapy and to patients burdened by the cumulative, side effects, complications, and compliance issues associated with drug therapy.

The G2 stent and applicator system are sized, dimensioned and configured for placement through trabecular meshwork in an ab interno or ab externo procedures. FIGS. **54A-C** illustrate additional examples of preferred G2 stent and applicator embodiments.

FIG. **54A** shows yet another embodiment of a stent injector assembly for multiple stent deployment, identified generally by the reference numeral **260**. The stent injector **260** comprises a housing **261** with a distal cap **262** and a distal stent-holding element **263** that is distal from the distal cap **261**. Optionally, at least a portion of the distal stent-holding element **263** can be configured to be steerable with a steering mechanism that can be constructed in accordance with the description of the steerable section **251** described above with reference to FIGS. **51A-D**.

The stent-holding element **263** can comprise an elongate member **264** with at least one stent slidably disposed thereon. The elongate member **264** can be configured to extend through the lumen of any of the stents **229A**, **229B**, **229C**, **229D**, **229E**, **229F**, or any of the other stents described below.

In the illustrated embodiment, the elongate member **264** extends through the lumen of stents **229G** (FIG. **54B**). In one embodiment, the distal stent **229G** can be the same as the second or proximal stent **229G**. In another embodiment, the distal stent and the proximal stent are different in size or configuration for placement at different locations. For example, the proximal and distal stents of FIG. **54B** can be any combination of the stents **229A**, **229B**, **229C**, **229D**, **229E**, **229F**, and **229G**. Additionally, the applicator **260** can be configured to be loaded with only one, three, or more stents.

In the illustrated embodiment, the distal flange **237G** of the stent **229G** can be wedge-shaped. For example, the distal end

of the flange **237G** can have a smaller diameter than that of the proximal end of the flange **237G**. As such, the stent **229G** can pass more easily through the trabecular meshwork **21**. Additionally, the distally facing surface of the flange **237G** can be inclined so as to be aligned with a distal surface of the elongate member **264**. As noted above with respect to the cutting member **250**, the elongate member **264** can be in the form of a trocar.

The stent-holding element further comprises a sleeve **265** configured to support the elongate member **264**. The sleeve **265** (for example, made of hypo tubing) can be pressed or bonded onto the distal cap **262** to form a sleeve-cap subassembly. The elongate member **264** can be configured to be axially moveable relative to the sleeve **265**, as indicated by the arrow **266** (FIG. **54C**).

The housing **261** can also comprise a tip actuator **267** that has a distal end **268** and a proximal end **269**. The elongate member **264** can be press fit or bonded into the distal end portion of the tip actuator **267** to form a tip/tip actuator subassembly. In one exemplary but non-limiting embodiment, the elongate member **264** can be a 0.08 mm diameter sharpened rod made from a hard material, such as a metal.

The tip/tip actuator subassembly is fed through the sleeve-cap subassembly and the cap **262** is screwed onto or bonded with the housing **261**. The proximal end **269** can include a threaded portion **270** adapted for threaded engagement with a rotation knob **271** located at the proximal end portion of the housing **261**. Thus, the coupling mechanism comprises the tip/tip-actuator subassembly screwed into the rotation knob **271** to form an actuator-knob subassembly.

An interlock arrangement **272** is configured to retain the knob **271** on the housing **261** and allow the knob **271** to rotate relative to the housing **261**. The interlock arrangement **272** can include an annular rib disposed on the housing **261** and a groove disposed on the knob **271**. A clearance is provided between the groove and the rib so as to allow the knob **271** to rotate freely relative to the housing **261**. The knob **271** can be pressed onto the housing **261** and thus spins freely on housing **261** without coming off because of an interlock arrangement **272**.

With reference to FIGS. **54A** and **54C**, the housing **261** can include a slot line **273** at a location perpendicular to a longitudinal axis **275** of the housing. One side of the slot line **273** can be drilled through to the opposite side of the housing, thus allowing an anti-rotation pin **274** to extend therethrough.

FIG. **54C** shows a top cross-sectional view, identified as section 3-3 of FIG. **54A**, with the anti-rotation pin **274** aligned with the slot **276**. During assembly, of the injector **260**, the tip actuator **267** is rotated until the slot **276** is aligned with the drilled hole adapted for the anti-rotation pin **274** to extend into the drilled hole. The anti-rotation pin **274** is pressed through a first side of housing, through the tip actuator, and through a second opposite side of housing.

In operation, one or more stents are placed over the member **264** and against the blunt front end of the sleeve **265**. After the injector approaches the target site, the elongate member **264** and the first stent are pressed into tissue where implantation is to take place. In an ab interno procedure, the first tissue is the trabecular meshwork facing the anterior chamber. In an ab externo procedure, the first tissue is the trabecular meshwork facing Schlemm's canal. Once the first stent is in a proper location, the knob **271** is rotated to withdraw the elongate member **264**, leaving the first stent in place. Stents can be snugly held onto the tip **264** with a mechanical feature on the elongate member, such as the holding members **245** described above with reference to FIGS. **51A-D**. Optionally, the sleeve **265** can include a mechanical feature for holding

stents in place. Further viscoelastic material or other means can be provided for holding the stents so that stent deployment does not occur until desired.

After the first stent is implanted, the injector is slightly withdrawn away from the trabecular meshwork. The tip of the injector is moved and pointed to a second target site without withdrawing the injector from the incision on the sclera. This re-positioning of the injector can be accomplished with a steerable section of the injector **260** noted above.

The term "targeted placement" of trabecular stents refers to the intentional placement of a stent at a particular location in Schlemm's canal for the purpose of providing a maximum benefit in the form of maximum outflow facility. With reference to FIG. **50A**, aqueous enters Schlemm's canal **22** through the trabecular meshwork **21** and travels along the canal to exit through the collector channels **23**. Schlemm's canal is a narrow channel with approximate dimensions of 250  $\mu\text{m}$   $\times$  20  $\mu\text{m}$  with a 40 mm length (Volume  $\sim$  0.2  $\mu\text{l}$ ) and it provides measurable resistance to the flow of aqueous. Therefore, placing a stent into Schlemm's canal **22** through the trabecular meshwork **21** yields the best improvement in outflow facility when it is placed near a large collector channel **23** or a group of smaller ones that combine to have a larger hydraulic diameter. It is one aspect of the present invention to locate/detect the most appropriate collector channel(s) to implant a trabecular shunting stent adjacent the collector channel(s) **23**.

FIGS. **55A-C** show multiple views of an embodiment of a trabecular stent shaped generally as a bee-stinger. The bee-stinger stent **309** is virtually axisymmetric. Multiple stents can be loaded in a stacked configuration within a sleeve of the stent delivery applicator. A trocar preferably runs axially through the stacked stents. The trocar possesses a sharp tip (that is, piercing member) so that it can penetrate the cornea and the trabecular meshwork. A stent implantation system may comprise different type of slidable piercing members including, but not limited to, those cited in U.S. patent application Ser. No. 10/231,342 filed Aug. 28, 2002, entitled GLAUCOMA STENT FOR TREATING GLAUCOMA AND METHODS OF USE, the entire contents of which are hereby incorporated by reference. Wires **301** (that is, anchoring wires or protrusions) arrayed around the perimeter of the outflow orifice fold inward as the stent is pushed through the trabecular meshwork or as loaded in a sheath for application. Once inside Schlemm's canal, the wires reassume their open geometry. In this position, they serve to hold open Schlemm's canal.

Deployment of each stent is achieved either through activation of a piston, plunger or the retraction of the trocar sleeve of the applicator. Multiple stents can be injected without reloading the applicator. Pores **302** (that is, fluid outlet ports) arrayed circularly around the stent surface provide many outflow paths for aqueous flow that enters from the inflow orifice **304** through the stent lumen **303** (that is, fluid passageway). This design presents several advantages. The wires may help to hold Schlemm's canal open and the multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implantation as a result of axisymmetric stent design. The cylindrical design should simplify manufacturing process. And the stent can pass through a smaller corneal incision as a result of the stent being crushed during delivery.

In one embodiment, it is contemplated that the wires **301** are inserted into the back wall of Schlemm's canal and into the sclera to assist in anchoring the stent in place. In this embodiment, the stent and the trocar are inserted through the

41

trabecular meshwork and into a portion of the sclera beyond Schlemm's canal. The trocar is removed, and the stent is left in place with the wires protruding into the sclera.

FIGS. 56 A-B show various views of a foldable umbrella trabecular stent. In one embodiment, the foldable umbrella stent **319** is essentially axisymmetric. Multiple stents can be loaded in a stacked configuration onto a trocar of a delivery applicator, and held in place within a sleeve. The tip of the trocar is configured sharp enough that it can penetrate the cornea and the trabecular meshwork. The outflow flange **311** of the stent folds inward as the stent is pushed through the created opening in the trabecular meshwork. Once inside Schlemm's canal, the outflow flange reassumes its open geometry. Deployment of each stent is achieved either through activation of a piston, plunger or the retraction of the trocar sleeve. Multiple stents can be injected without reloading the applicator.

In one embodiment, the stent is provided with a center outflow port **312** connected to the stent lumen **314** and a plurality of side outflow ports **313**. The foldable umbrella trabecular stent has the benefits and advantages. The angled outflow flange may hold Schlemm's canal open. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implantation as a result of axisymmetric stent design. And the stent can pass through a smaller corneal incision as a result of the stent being crushed during delivery.

FIGS. 57 A-B show various views of a trabecular stent having a modified center bulb **324** with anchors. In one embodiment, the center-bulb-with-anchor stent **329** is axisymmetric. In one embodiment, stents can be loaded in a stacked configuration onto a trocar of a delivery applicator, and held in place within a sleeve. The tip of the trocar is sharp enough that it can penetrate the cornea and the trabecular meshwork. In another embodiment, the stent possesses a sharp tip (not shown) so that it can penetrate the cornea and the trabecular meshwork, whereas stents can be loaded in a stacked configuration within a sleeve.

An applied force will bury the sharp tip and grooves **325** into the scleral wall of Schlemm's canal. An outwardly expandable scleral anchor arrangement **323** is provided at the distal end of the stent **329**. The sclera will tend to conform to the exterior surface of the sharp tip and grooves. Tissue extending into the grooves will assist with retention strength. Once in position, the outflow ducts **322** bulge open by means of the superelastic properties of a shape-memory material, e.g., Nitinol. The outflow ducts provide a dual purpose. First, they buttress Schlemm's canal; and second, they create multiple pathways for the outflow of aqueous via a stent lumen **321**.

Deployment of each stent is achieved either through the activation of the piston, or the retraction of the sleeve. Multiple stents can be injected without reloading the applicator. The trabecular stent having a modified center bulb with anchors has several advantages. Schlemm's canal would be buttressed open by the outflow ducts of the bulb portion. If deployed properly, the bulb will serve to add retention strength. Grooves will bolster the retention strength. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implantation as a result of axisymmetric stent design. The multiple pores help prevent aqueous clogging. Shape-setting and other memory-shape material, such as Nitinol, are well understood procedure and products. And cylindrical design should simplify manufacturing process.

FIGS. 58 A-B show various views of a mushroom trabecular stent. In one embodiment, the mushroom stent **339** is

42

axisymmetric. Stents can be loaded in a stacked configuration onto a trocar. The tip of the trocar is sharp enough that it can penetrate the cornea and the trabecular meshwork. The domed, or partially bulbous, outflow surface **331** of the stent further widens the openings in the cornea and meshwork. Deployment of each stent is achieved either through activation of a piston, plunger or the retraction of the trocar sleeve. Multiple stents can be injected without reloading the applicator. Once positioned, the domed outflow surface of the stent buttresses Schlemm's canal. Pores **332** arrayed circularly around the domed outflow surface provide many outflow paths for aqueous flow. The flange **333** is for enhancing the stent retention at trabecular meshwork.

The mushroom trabecular stent has several advantages. The domed outflow surface may hold Schlemm's canal open. The multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. And rotational orientation is not required during implant as a result of axisymmetric stent design.

FIGS. 59 A-C show various views of a rivet trabecular stent **349**. Multiple stents can be loaded in a stacked configuration onto a trocar. The tip of the trocar is sharp enough that it can penetrate the cornea and the trabecular meshwork. After deployment in place, the rivets **341** tend to expand radially outwardly to anchor the stent within sclera wall of Schlemm's canal while the outlets of the stent (depicted in the rivets **341**) may be configured to remain within Schlemm's canal.

FIGS. 60 A-B show various views of a trabecular stent with scleral anchors. In one embodiment, the scleral anchor stent **359** is axisymmetric. Stents can be loaded in a stacked configuration within a sleeve. The stent possesses a sharp barbed tip **351** that is sharp enough that it can penetrate the cornea and the trabecular meshwork. The domed outflow surface **352** of the stent further widens the openings in the cornea and meshwork. An applied force embeds the barbed tip into the scleral wall of Schlemm's canal thus creating a scleral anchor.

Deployment of each stent is achieved either through activation of the piston, plunger or the retraction of the sleeve. Multiple stents can be injected without reloading the applicator. Once positioned, the domed outflow surface of the stent buttresses Schlemm's canal. Pores **353** arrayed circularly around the domed outflow surface provide many outflow paths for aqueous flow. The flange **354** is for enhancing the stent retention at trabecular meshwork. The domed outflow surface may hold Schlemm's canal open. The multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. And rotational orientation is not required during implantation as a result of axisymmetric stent design.

FIGS. 61 A-B show various views of another trabecular stent with scleral anchors. In one embodiment, the alternate scleral anchor stent **369** is axisymmetric. Stents can be loaded in a stacked configuration within a trocar sleeve. The stent possesses a sharp tip **361** that can penetrate the cornea and the trabecular meshwork. An applied force will embed the sharp tip and grooves into the scleral wall of Schlemm's canal thus creating a scleral anchor while a plurality of outlet pores **363** are configured to remain with Schlemm's canal to permit flow of aqueous therethrough. The sclera will tend to conform to the exterior surface of the sharp tip and grooves **362**. Tissue extending into the grooves will assist with retention strength.

Deployment of each stent is achieved either through activation of the piston, plunger or the retraction of the sleeve. Multiple stents can be injected without reloading the applicator. The pores **363** are arrayed circularly around the domed outflow surface and provide many outflow paths for aqueous

flow. The multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implantation as a result of axisymmetric stent design. Grooves will bolster retention strength. And cylindrical design should simplify manufacturing process.

FIGS. 62 A-B show various views of a trabecular stent with a screw. In one embodiment, the screw stent 379 is generally not axisymmetric. Stents can be loaded in a stacked configuration within a trocar sleeve. A trocar may extend through the axis of the stents. The trocar could possess a sharp tip so that it can penetrate the cornea and the trabecular meshwork. A pilot hole can be created in the scleral wall of Schlemm's canal using the trocar. After the meshwork has been punctured, the threads 371 of the stent can be screwed into the scleral wall of Schlemm's canal, thus creating a scleral anchor. Twisting motion can be accomplished through the use of a piston or other feasible means. Deployment of each stent is achieved either through activation of the piston with rotating means or the retraction of the sleeve. Multiple stents can be injected without reloading the applicator. Pores 372 arrayed circularly around the domed outflow surface provide many outflow paths for aqueous flow. The multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implant as a result of axisymmetric stent design. Threads will bolster retention strength. And recessed shaft of the stent may aid with preventing the meshwork from staying pinched shut.

FIGS. 63A-B show various views of a spike trabecular stent. In one embodiment, the spike stent 389 is axisymmetric. Stents are stack-loaded onto a trocar, and kept in place via friction or other retention means. The tip of the trocar is sharp enough that it can penetrate the cornea and the trabecular meshwork with little effort. Deployment of the stent is achieved by advancing the push tube inside the applicator. An applied force will embed the sharp edge of the stent into the scleral wall of Schlemm's canal thus creating a scleral anchor. Multiple stents can be injected without reloading the applicator. Pores 381 arrayed circularly around the cylindrical wall provide many outflow paths for aqueous flow.

In one embodiment, all pores are sized and configured to expose to Schlemm's canal alone so as to pressurize Schlemm's canal before, after, or during stent implantation. In another embodiment, the pores are sized and configured to irrigate Schlemm's canal, trabecular meshwork and/or sclera tissue of Schlemm's canal. The multiple pores help prevent aqueous clogging. Multiple stent deliveries can be achieved because the stent can be stacked in the applicator. Rotational orientation is not required during implantation as a result of axisymmetric stent design. And the tubular geometry simplifies the manufacturing process.

FIGS. 64A-B show a multiple blade mushroom stent 399 and its associated trocar delivery system. In one embodiment, the stent comprises at least one blade. In another embodiment, the stent 399 comprises dual blades, as depicted in FIG. 64B. In a further embodiment, the stent 399 comprises a distal terminal 391 to be placed in Schlemm's canal, a proximal terminal 392 to be placed in the anterior chamber, a middle portion with groove 393 to be placed in the trabecular meshwork, and a distal tip 394 with a plurality of blades 395. One or more multiple blade mushroom stents are placed inside the sleeve 396 of a stent delivery trocar 397.

In one preferred embodiment, the trocar comprises a tri-face trocar tip which is configured to be sharp enough that it can penetrate the trabecular meshwork or the sclera with little effort. In one embodiment of operations, the outer sheath 396

with sharp edge cuts the cornea. The sharp tip of the tri-face trocar 397 penetrates the trabecular meshwork, whereby the trocar is advanced via a pusher tube 398 into the trabecular meshwork until the meshwork rides over the outer sheath. Irrigation is achieved via fluid flow in a fluid passageway between the trocar and the outer sheath. After irrigation, the outer sleeve and trocar are retracted while holding the pusher tube in place. The meshwork would then reside in the stent groove 393. The multiple blades or sharp ends of the mushroom stent are sized and configured to cut and spread open the meshwork during stent insertion.

#### Controlled Stent Injection

With reference to the drawings, in FIGS. 65-72, an incision tip is shown with a plunger, within a trocar. The distal end of the plunger terminates adjacent a proximal end of a stent and the proximal end of the plunger is used for actuation. In operation, a trocar is brought to rest on the edge of trabecular meshwork, the plunger end is actuated to push the cutting end into trabecular meshwork and into a rear surface of the sclera beyond Schlemm's canal. The trocar provides an arrest against a stop element of the plunger, whereby the cutting edge travel is controlled to a distance D, just sufficient to provide a transscleral incision and placement of the stent. Withdrawal of the plunger removes the trocar cutting element from the slit/opening and the trocar is removed thereafter. The length of the cutting element is between about 1.0 mm and 3.5 mm, although the length could more less than about 1.0 mm or greater than about 3.5 mm. Some embodiments relate to a trocar with the distance D between about 100 microns to a few millimeters, preferably between about 200 microns to 500 microns, although it is contemplated that the distance D could be less than about 100 microns or greater than a few millimeters.

In some embodiments, the injector-type stent delivery applicator (also known as G2 injector) serves the purpose of driving a trabecular stent into Schlemm's canal with possibility of anchoring the distal tip of the stent into the sclera beyond Schlemm's canal. Furthermore, the G2 injector may supply irrigating fluid, e.g., saline, viscoelastic, to inflate the canal. Canal inflation can be performed before, after, or during stent insertion.

In one embodiment, the canal inflation can be achieved by pressurizing or fluid irrigation at one or more than one places along the circumference of Schlemm's canal; for example, at any of quadrant points of the circumference. In another embodiment, the fluid properties (viscosity, composition, drug inclusion, and the like) at more than one place along the circumference of Schlemm's canal may be different from each other. In a further embodiment, the stent delivery applicator comprises more than one applicator tip, wherein a first tip is provided for pressurizing Schlemm's canal and a second tip is provided for stent implantation without removing the applicator out of the eye.

FIG. 65 shows a perspective view of a G2 injector 401 whereas FIG. 66 shows a top view of the G2 injector of FIG. 65. The injector 401 comprises a body 402, a button 403 for deploying a trabecular stent that is held with a lumen of the stem 404, and a cap 405 that is accessible to any irrigating fluid. The injector and stem may be made of any rigid material, such as a metal or plastic. A cross-section of the stem 404 reveals the sharp-tipped trocar 407, stent 406, pusher tube 408, and outer tube 409 as shown in FIG. 67.

In one embodiment, the stem 404 is equipped with a solid trocar that moves back and forth within a lumen of the stent 406. In another embodiment, the stem is equipped with irrigation means for providing irrigating fluid to the injector 401. FIGS. 68A-C illustrate three modes of a side cross-sectional

45

view of a G2 injector stem, showing irrigating trocar portion. In a first mode as shown in FIG. 68A, the hollow trocar 410 comprises a sharp tip 411 for penetrating through tissue and a fluid passage lumen 412 sized and configured for fluid irrigating out of the end port 413 or out of at least one side port 414. After a desired slit or opening is created on the tissue by the sharp tip 411, the trocar 410 is retracted as shown in FIG. 68B. In a later mode as shown in FIG. 68C, the stent 406 is ready to be deployed and implanted in place. As illustrated, fluid irrigation or canal inflation can be performed before, after, or during stent insertion.

FIG. 69 shows two modes of the G2 injector: (A) in the cocked orientation and (B) in the deployed orientation. Stent positioning is performed while the injector 401 is in the cocked orientation. Delivery is accomplished during the motion between the cocked and deployed orientations. This action is triggered with the push of the button. During the loading phase, the stent is loaded onto the trocar 407 when the injector is in the deployed orientation. Loading is accomplished by sliding the stent onto the trocar. The proximal end of the stent preferably seats against the pusher tube. During the cocking phase, the injector 401 is put into the cocked orientation after loading the stent. This is accomplished by rotating the button. The button 403 has an angled slot 421 that the pusher tube resides in during the deployed orientation. FIGS. 70 A and B show two pusher tube locations of the button geometry. As this button is rotated, the pusher tube is forced out of the slot and onto the outer surface 422 of the button shaft 420.

FIG. 71 shows a schematic illustration of effective shorting of a pusher tube in the G2 injector, whereas FIG. 72 illustrates where the pusher-tube resides when the G2 injector is cocked. The button rotation forces the pusher tube 408 to bow from a first position 408B to a second position 408A. Ultimately, this action accomplishes effective shortening of the pusher tube distance extending beyond the interior body. Since the trocar may reside inside of the pusher tube, it too may bow and become effectively shortened. Springs 425 apply a force to the bowed pusher tube 408.

In one embodiment, the button 403 can be rotated 360 degree as shown in FIG. 72. During the rotation, the button may raise axially a slight amount. The pusher tube 408 may reside on the button, just below the slot 421 until it is deployed. When deployed, the pusher tube 408 preferably resides in the slot 421.

The term "Multi-stent therapy" refers to the intentional placement of a stent in each of several locations in Schlemm's canal 22. Since Schlemm's canal 22 has measurable resistance to flow at physiological flow rates, a plurality of stents is strategically placed close to concentrations of collector ducts 23 or a large collector and distributed around Schlemm's canal 22 to maximize the impact of multiple stents.

An injector or device applicator to hold a plurality of serial devices has advantages of placing the device one at a time without reloading the device or without completely withdrawing the applicator out of a portion of the body. The advantages may include saving operating time, reducing redundant incision or injury, or exact positioning for device placement.

By way of example, but without limitation, an injector or device applicator for multiple device deployment may be used for implanting punctum plugs in an eye, for implanting drug-eluting devices into sclera tissue of an eye, implanting drug-eluting devices into tissue of a posterior segment, or implanting cardiovascular stents. Some embodiments relate to a method of multiple device deployment comprising: (a)

46

loading a plurality of devices within a device-retaining space of a device applicator; (b) delivering the applicator to a first target implant site; (c) deploying a first device at the first target implant site; (d) detaching the applicator from the first target implant site; (e) directing the applicator to a second target implant site; (f) deploying a second device at the second target implant site; and (g) withdrawing the applicator.

The device of the exemplary embodiment preferably comprises a biocompatible material such that inflammation arising due to irritation between the outer surface of the device and the surrounding tissue is minimized. Biocompatible materials which may be used for the device 81 preferably include, but are not limited to, titanium, titanium alloys, polypropylene, nylon, PMMA (polymethyl methacrylate), medical grade silicone, e.g., SILASTIC™, available from Dow Corning Corporation of Midland, Mich.; and polyurethane, e.g., PELLETHANE™, also available from Dow Corning Corporation.

In other embodiments, the device of the embodiments may comprise other types of biocompatible material, such as, by way of example, polyvinyl alcohol, polyvinyl pyrrolidone, collagen, heparinized collagen, polytetrafluoroethylene, expanded polytetrafluoroethylene, fluorinated polymer, fluorinated elastomer, flexible fused silica, polyolefin, polyester, polysilicon, and/or a mixture of the aforementioned biocompatible materials, and the like. In still other embodiments, composite biocompatible material may be used, wherein a surface material may be used in addition to one or more of the aforementioned materials. For example, such a surface material may include polytetrafluoroethylene (PTFE) (such as TEFLON™), polyimide, hydrogel, heparin, therapeutic drugs (such as beta-adrenergic antagonists and other anti-glaucoma drugs, or antibiotics), and the like.

Although preferred embodiments of the inventions have been described in detail, including a method for treating glaucoma comprising placing a plurality of trabecular stents for transporting aqueous from an anterior chamber to Schlemm's canal, certain variations and modifications will be apparent to those skilled in the art, including embodiments that do not provide all of the features and benefits described herein. It will be understood by those skilled in the art that the present inventions extend beyond the specifically disclosed embodiments to other alternative embodiments and/or uses of the present inventions and obvious modifications and equivalents thereof. In addition, while a number of variations of the present inventions have been shown and described in detail, other modifications, which are within the scope of the present inventions, will be readily apparent to those of skill in the art based upon this disclosure. It is also contemplated that various combinations or subcombinations of the specific features and aspects of the embodiments may be made and still fall within the scope of the present inventions. Accordingly, it should be understood that various features and aspects of the disclosed embodiments can be combined with or substituted for one another in order to form varying modes of the present inventions. Thus, it is intended that the scope of the present inventions herein disclosed should not be limited by the particular disclosed embodiments described above.

What is claimed is:

1. A system for treating an ocular disorder, comprising:
  - an implant comprising an anchor on a distalmost end portion of the implant, the distalmost end portion being closed;
  - a therapeutic agent; and
  - a delivery device comprising an elongate body and configured to insert the implant on one side of an eye, advance the implant across the eye to an other side of the eye, and



47

insert the anchor into eye tissue on the other side of the eye so that the anchor penetrates only partially into a sclera of the eye.

2. The system of claim 1, wherein the therapeutic agent is part of the implant.

3. The system of claim 2, wherein the implant has a body and the therapeutic agent is part of the body of the implant.

4. The system of claim 1, wherein the therapeutic agent is appended to the implant.

5. The system of claim 1, wherein the therapeutic agent is coated on a surface of the implant.

6. The system of claim 1, wherein at least a portion of the implant is configured to elute the therapeutic agent into the eye.

7. The system of claim 1, wherein the implant is configured to deliver the therapeutic agent through the outlet opening.

8. The system of claim 1, wherein a portion of the delivery device is configured to transport the therapeutic agent into the eye.

9. The system of claim 1, wherein the implant comprises a controller to control fluid flow through the implant.

48

10. The system of claim 1, wherein the controller comprises a valve.

11. The system of claim 1, wherein the anchor comprises a structure selected from the group consisting of a conical shape, a screw, at least one protrusion, and a circumferential indentation.

12. The system of claim 1, wherein the anchor comprises a sharp end.

13. The system of claim 12, wherein the sharp end of the anchor is at a distal-most end of the distal end portion.

14. The system of claim 1, wherein the implant comprises at least one inlet opening in fluid communication with an outlet opening disposed proximal of the anchor.

15. The system of claim 1, wherein the delivery device is configured to advance the implant across an anterior chamber of the eye.

16. The system of claim 1, wherein the delivery device is configured to access an anterior chamber of the eye and introduce the implant into the anterior chamber through the incision.

\* \* \* \* \*